TILLMON
TRAINING & CONSULTING

Pilot Violence Prevention Program Strategic Plan (Phase 0)

Harris County, TX Precinct 1

Table of Contents

Introduction: The Public Health Approach to Violence-Prevention

Homicide and violent crime are pervasive public health problems in the United States (Centers for Disease Control and Prevention [CDC], 2019). Young people (ages 15-29) are disproportionately involved in violence perpetration and victimization within urban neighborhoods (Beardslee et al., 2018; Tisak, Tisak, Baker, & Graupensperger, 2019). Scholars and medical professionals argue that persisting high rates of violence combined with consequent widespread and debilitating community-level harm necessitate a public health approach to violence-prevention (e.g., Delaney-Black et al., 2002; Dubow, Huesmann, & Boxer, 2009; Irvin-Erickson, Bing, Gurvis, & Mohr, 2016; Jewkes, Dunkle, Nduna, & Shai, 2010). Recent data suggest that homicide is on the rise in the United States. In 2019, 16,425 people were murdered, a 3.4% increase from 2015 and a 11.6% increase from 2010 (U.S. Department of Justice [DOJ], 2020a, b). Among murder victims, 53.7% were Black, 45.1% were White, and 15.7% were Hispanic (U.S DOJ, 2020a,b). The majority of homicides in the U.S. involve male victims, and 73.7% of lethal violence is committed with a firearm (U.S DOJ, 2020a,b).

Relevant to Harris County, Texas, in 2019 nearly half (48.7%) of all murders in the U.S. were reported in the South (U.S. DOJ, 2020a,b). The Texas Department of Public Safety (2020) reported 1,403 homicides (4.8 murders per every 100,000 people) in 2019, a 6% increase from 2018. Among those homicides, 80.2% were committed with firearms and the majority by males and individuals aged 25-29 followed by 15-19. Harris County homicides comprise approximately 7% of all Texas murders. Data also reveal that of the 745 arrests for murder/non-negligent manslaughter in 2019, 47.4% were Black (n=352) and 29.4% (n=213) were Hispanic.

Unique to other regions in the U.S., 43.7% of the Harris County population is of Hispanic/Latino ethnicity (U.S. Census Bureau, 2020). Hispanics/Latinos/as and African

Americans together make up 63.7% of the Harris County population (U.S. Census Bureau, 2020). Racial/ethnic concentrations in U.S. communities coupled with factors such as immigration may influence how violent crime occurs (Harris & Feldmeyer, 2013). Research largely refutes popularized and political contentions that immigration contributes to increased crime levels in communities (Harris & Feldmeyer, 2013; see also Lee, Martinez, & Rosenfeld, 2001; Shihadeh & Barranco, 2010a; Stowell, 2007). Several prominent studies indicate that immigration has null or crime-reducing effects within neighborhoods (see Feldmeyer, 2009; Lee et al., 2001; Martinez, 2002; Martinez, Stowell, & Lee, 2010; Ousey & Kubrin, 2009; Sampson & Bean, 2006; Vélez, 2006). Immigration often bolsters community resources, institutions, and shelters providing violence-protective effects (Harris & Feldmeyer, 2013; Martinez et al., 2010; Sampson & Bean, 2006). New immigration into established destinations (such as Harris County) provide "a fresh infusion of shared heritage and reinforcing the community's common language, traditions, and conventional values," as well as strengthen immigrant familial/kinship ties and social capital networks (Feldmeyer, 2009; Harris & Feldmeyer, 2013, p. 205; Lee et al., 2001; Martinez, 2002; Vélez, 2006). Collectively, such effects provide greater informal social control of violent crime (Alba & Nee, 1997; Harris & Feldmeyer, 2013; Leach & Bean, 2008; Light & Gold, 2000; Portes & Rumbaut, 2006). At the same time however, some research suggests that Latino immigration may contribute to violence committed by Blacks because both groups share somewhat similar job skill profiles that may increase competition for employment within typically low-income, hourly labor market positions thus elevating violence rates (Harris & Feldmeyer, 2013; Shihadeh & Barranco, 2010b). Consequently, Latino immigration may impact violence for groups such as Latinos and Blacks more so than other groups such as Whites (28.7% of the Harris County population; U.S. Census Bureau, 2020) (Harris & Feldmeyer, 2013).

Similarly, research shows a strong relationship between structural disadvantage and crime wherein high-levels of poverty, income inequality, joblessness, and lack of education intersect with racism and discrimination to create oppressive and marginalizing conditions that elevate levels offending and victimization (Curry et al., 2008; Dupéré & Perkins, 2007; Mair et al., 2010; O'Campo et al., 2015; Ross & Mirowsky, 2001; Stockdale et al., 2007; Tcherni et al., 2011; Weisburd et al., 2018). Community-level disadvantage within high-violence areas limits individuals' ability to envision or access alternatives to violent behavior, environmental conditions, and/or opportunities providing life enhancement or economic and personal well-being (Allard & Smith, 2014; Galea et al., 2007; Murphy & Wallace, 2010; Weisburd et al., 2018). Such violence-proliferating conditions overlapping with limited access to helping-resources and social capital reduce traversable pathways out of violence and crime, and associated health, self-sufficiency, and overall security and happiness. Negative structural conditions create omnipresent detrimental individual- and community-level effects that endanger family and community health and safety (McCollister, French, & Fang, 2011).

Homicide is the most extreme consequence of a larger public health crisis. In 2019 in the U.S., there were an estimated 821,182 aggravated assaults with 27.6% committed with firearms (U.S. DOJ, a,b). Within Harris County, 4,123 aggravated assaults were reported in 2019, which comprises 15.1% of the 27,300 aggravated assaults reported overall throughout Texas (Texas Department of Public Safety, 2020). Hispanics and Blacks had close to equal arrest levels for aggravated assault – Hispanics comprising 35.4% (n=9,669) of arrests, and Blacks comprising 36.2% (n=9,993) of arrests (Texas Department of Public Safety, 2020). Violence adversely affects any community regardless of race/ethnicity, geography, and socioeconomic status; however, Black and Hispanic males in the U.S. are at higher risk of firearm and other forms of

violent-injury than White males (Weisburd et al., 2018), and homicide is the fourth leading cause of death among African American males of all ages (CDC, 2017).

The public health approach to violence-prevention has gained prominence and popularity over the past 20+ years. The CDC (2020) developed a standardized model for designing effective violence-prevention programs, which emphasizes the health, safety, and well-being of national, urban, and community-based populations, and works to pervade and maximize benefits across entire geographic landscapes. The method embodies the vision that violence to any degree is a major contributor to premature death, disability, and injury. This approach is informed by scientific knowledge specific to the detrimental and all-encompassing effects of violence on public health outcomes (e.g., Diez-Roux & Mair, 2010; Franco, Diez-Roux, Glass, Caballero & Brancati, 2008; LaVeist & Wallace, 2000). It is multi-disciplinary and relies on input from varying sectors, including health, education, social services, justice, policy, community-level social services, and the private sector to foster a sophisticated understanding of violence responsive to its complexity and collective action to prevent it (CDC, 2020).

The CDC's (2020) 4-prong violence-prevention approach involves first, (1) defining and monitoring the problem; next, (2) identifying risk and protective measures; then (3) developing and testing prevention strategies; and finally, (4) implementing and adopting effective strategies widescale. This method is informed by application of a socio-ecological model consisting of four overlapping rings to assess how a diverse range of factors at the (1) individual (smallest ring), (2) relationship (second largest ring), (3) community (third largest ring), and (4) social (largest ring) levels operate to increase perpetration and victimization risk. That is, the latter consequences are influenced by (1) biological and personal history factors (e.g., age, income, substance use, and abuse history) at the "individual-level;" (2) a person's close relationships (e.g., peers, partners,

family members) at the "relationship-level;" (3) environments such as schools, workplaces, and neighborhoods where people form social relationships and engage at the "community-level;" and finally, (4) broad societal factors such as social and cultural norms at the "social-level." The CDC (2020) advises direct action across multiple levels of the model simultaneously in order to create and sustain violence-prevention strategies across time. The World Health Organization (WHO; 2010) has publicly recognized the public health approach as the most effective strategy to inhibiting violence, and has adopted it as its key policy for global violence-prevention.

Under the public health philosophy umbrella, Dr. Gary Slutkin (2013; Slutkin, Ransford, & Zvetina, 2018), an infectious disease specialist and former CDC epidemiologist[1], proposed treating violent crime like an infectious disease epidemic. Violence, like disease, causes mortality and injury/illness, and can be considered contagious as it spreads from person-to-person within areas where high-levels of prior exposure to violence exist and perpetuate (Slutkin et al., 2018). Slutkin's research revealed that approaches to controlling disease epidemics also effectively operate to reduce violence and violence-related deaths (see Delgado et al., 2017; Picard-Fritsche & Cerniglia, 2017; Skogan, Hartnett, Bump, & Dubois, 2009; Webster, Whitehall, Vernick, & Parker, 2012). In 1999, he launched the Chicago-based violence-prevention program currently known as, "Cure Violence" (formerly CeaseFire[2]) at the University of Illinois at Chicago's School of Public Health, which has spread rapidly across the United States and globe as one of the most preferred and effective violence-prevention approaches (i.e., 50 sites across 25 U.S. states, and 15+ countries across the globe – Canada, Latin America and the Caribbean, the Middle East, Africa, and Europe) (Cure Violence Global, 2020). The Cure

[1] Epidemiology involves the study of diseases or health-related problems in the larger population.
[2]CeaseFire was an early iteration of the model that began in 1999 as part of the Chicago Project for Violence Prevention (CPVP).

Violence model focuses on (1) finding and disrupting conflicts, (2) identifying and obtaining treatment and assistance for individuals who are highest risk, and (3) changing social norms, and relies primarily on highly-trained community-organizers with intimate understanding of community-level violence to implement its strategy (Cure Violence Global, 2020). This model works across all four levels of the socio-ecological model.

Specific to the pervasive detrimental public health effects of violence, Slutkin and colleagues (2018) explained: “Violence not only causes injury and death; it also erodes the physical, psychological, social, and economic health and development of nearly everyone in affected communities, reducing life expectancy, inflicting trauma, limiting opportunity and achievement, and further entrenching inequities” (p. 47). Violence also reduces productivity, deteriorates communities through decreasing property values and minimizing gainful employment/infrastructure investments, and disrupts the capacity of underfunded social services to effectively respond (CDC, 2020).

The Cure Violence model serves as an alternative to traditional criminal justice, deterrence-based, and punitive responses to crime (i.e., law enforcement, courts, and incarceration) (CDC, 2020; Cure Violence Global, 2020) that are sometimes ineffective at reducing or worsen violence (see Lessing, 2018). The criminal justice system has historically been the primary social mechanism used to solve or control urban violence wherein cities/governments invest in police hiring or department infrastructure to heavily target “hot spots” of crime (Weisburd et al., 2018). A meta-analysis revealed however that such investments and methods affect only small reductions in crime (Braga, Papachristos, & Hureau, 2014; see Cerdá, Tracy, & Keyes, 2017). However, the persistence of urban violence and increasing concerns about racial bias in policing and officer use of unjust force/violence against

marginalized community members has generated increased public interest in alternative approaches to violence-prevention (Cerdá et al., 2017; Prothrow-Stith & Spivak, 2003).

The Literature Review below first summarizes scholarship specific to the public health philosophy of violence-prevention. Next, research is examined specific to three community-level violence-prevention programs that operate to enhance public health and resilience. These programs are implemented within the communities most-affected by violence and range from basic and direct to all-encompassing. Harris County may consider adopting and tailoring one of these three models to violence prevention, or can, for example, apply model option 2 and add additional components across time responsive to community violence-prevention needs and concerns both persisting and changing:

1. **Basic and direct violence-prevention approach**: The "Cure Violence" programs in Chicago, IL and Baltimore, MD (known as "Safe Streets") utilize "violence interrupters" and outreach workers (Chicago) or a hybrid of both (Safe Streets) to identify potential violent conflict and interrupt escalation; provide high-risk individuals with needed resources to encourage ongoing desistance from violent behavior; and foster community understanding of and motivation toward preventing violence and its terrible effects.

2. **Coordinated wrap around violence-prevention approach**: New York City's, "Crisis Management System" (CMS) utilizes hybrid violence interrupters and outreach workers known as "credible messengers" to work in collaboration with multiple wrap around support services (e.g., legal, job training, school conflict mediation, and mental health) to disrupt violence and create a safety net infrastructure for high-risk individuals to prevent it long-term.

3. **All-encompassing violence-prevention approach**: Milwaukee, WI's, "Blueprint for Peace: 414Life" program uses comprehensive, tailored services provision and collaboration between the government, 414Life, law enforcement, and community-level services providers to enhance community-building, address inequities specific to racial and structural oppression, and build individual and community resilience to prevent all forms of violence, including domestic and sexual violence and child maltreatment.

Literature Review

Detrimental Public Health Effects of Violence

The CDC (2020) indicates that people who witness violence (e.g., assault, homicide, gang violence, domestic violence, gun violence, etc.) are at a higher risk of perpetrating violence (see also Slutkin, 2013; Slutkin et al., 2018), thus perpetuating the problem and its harms. Research demonstrates that witnessing, falling victim to, or participating in violent, traumatic events are significantly associated with physical and/or mental health maladies/injuries that may be exacerbated by higher likelihood of multiple and recurring forms of violent victimization (Brown, Hill, & Lambert, 2005; Buka, Stichick, Birdthistle, & Earls, 2001; CDC, 2020; Ronzio, Mitchell, and Wang, 2011; Weisburd et al., 2018). The negative effects of violence and associated detrimental health outcomes can permeate the social fabric of communities endangering individual, family, community, and social health, and have profound, lifelong, detrimental effects on opportunities and well-being (CDC, 2020; Felitti et al., 1998; Irvin-Erickson et al., 2016; Jewkes et al., 2010; McCollister, French, & Fang, 2011; Slutkin et al., 2018). Violence causes profound harm to child development, population-wide long-term health, and community economic development, especially among communities of color (American Public Health Association, 2018).

Mental Health

Scholars have examined the relationship between violence and mental health across urban landscapes. Research has found that individuals living in neighborhoods with high levels of violence experience elevated stress and other mental health problems such as depression and anxiety when compared to those living in non-violent neighborhoods (Curry, Latkin, & Davey-Rothwell, 2008; Dustmann & Fasani, 2016; Stockdale et al., 2007; Weisburd et al., 2018).

Similarly, people who witness community violence experience symptoms of depression and anxiety measurably more so than those who do not (Buckner, Beardslee, & Bassuk, 2004; Clark, Ryan, Kawachi, Canner, & Wright, 2008; Weisburd et al., 2018).

Racial/ethnic minority youth and adults often live in urban communities with high-levels of poverty and resource deprivation, which may elevate their risk of exposure to environmental and social risk factors strongly associated with anxiety (Anderson & Mayes 2010; Burgers & Drabick, 2016). Exposure to violence is particularly dangerous for young Black males who live in low-income communities with high rates of crime/deviance; repeated exposure to violence makes it more likely that they will experience physical or psychological trauma (Gaylord-Harden et al., 2017). Further, survivors of gun violence often are so traumatized by their experience that they return home without adequate or any treatment for mental health conditions, such as posttraumatic stress disorder (Picard-Fritsche & Cerniglia, 2010; Wical, et al., 2020). Residing in areas where violence is common may increase exposure to violence, victimization, fear, withdrawal, and avoidance behavior that can negatively impact residents' mental health (Braakman, 2013; Butcher, Galanek, Kretschmar, & Flannery, 2015; Diez-Roux & Mair, 2010; Fitzpatrick, Piko, Wright, & LaGory, 2005; Mair, Diez-Roux, & Morenoff, 2010; Pearson, Breetzke & Ivory, 2015; Weisburd et al., 2018). For example, exposure to traumatic/violent events is related to people displaying pronounced and increased post-traumatic stress disorder (PTSD) symptomology (Alim, Charney, & Mellman, 2006; Goldman et al., 2011; Kilpatrick & Acierno, 2003). Goldman and colleagues (2011) examined the relationship between traumatic violent events and PTSD symptoms among 1,306 African American residents of Detroit where assaultive violence is commonly experienced. The study found that 87.2% of African Americans

were exposed to at least 1 traumatic violent event and 17.1% of those who had such experiences met criteria for lifetime probable experiences of PTSD symptomology.

Studies have also found that negative structural characteristics associated with neighborhood disorder and deterioration such as low socioeconomic status, residential instability, and frequent aggressive/violent social interactions and exposure to violence are positively associated with community-wide depression (see Galea et al.'s [2008] systematic review, and Mair, Diez-Roux, & Galea, 2008) and other mental health problems (Braakman, 2013; Butcher et al., 2015; Diez-Roux & Mair, 2010; Pearson et al., 2015; Weisburd et al., 2018).

Additionally, individuals directly (e.g., victims, perpetrators, and their families) and secondarily affected by violence (e.g., live within violence-prone communities, but have not directly experienced violence nor know the victim or perpetrator) exhibit avoidance behaviors embedded in mental illness (Kleiman, Caulkins, & Gehred, 2014). People who have directly experienced violence demonstrate "primary avoidance" behaviors involving high levels of fear of victimization and anxiety that fosters social isolation, inhibited liberty and sustained well-being, and diminished access to life-enhancement opportunities (Braakman, 2013; Butcher et al., 2015; Diez-Roux & Mair, 2010; Fitzpatrick et al., 2005; Mair et al., 2010; Pearson et al., 2015). Similarly, people who have not been directly victimized but live within high violence communities demonstrate "secondary avoidance" behaviors involving increased fear, anxiety, social hostility and withdrawal, and reduced job opportunities when businesses relocate to avoid recurring crime (Lugo & Przybylski, 2018).

The negative mental health consequences of violence can harmfully alter life trajectories and diminish the capacity of those affected to survive and thrive, which may, across time, weaken the capacity of communities to address violence and its harms, thus allowing both to

persist (see Braakman, 2013; Butcher et al., 2015; Diez-Roux & Mair, 2010; Fitzpatrick et al., 2005; Mair et al., 2010; Pearson et al., 2015; Weisburd et al., 2018).

Physical Health

In 2019, there were 29,501 willful, malicious, or accidental gun violence injuries nationally (Gun Violence Archive, 2020). Similarly, U.S. DOJ (2020) data reveal that there were 841,280 violence-related injuries (e.g., stab wounds, broken bones, skull fractures or blunt force trauma, internal injury, traumatic brain injury, spinal cord injuries, etc.) reported to police. Rates of nonfatal injuries from gun violence are higher than death rates from gun violence (CDC, 2020) and are often severe, resulting in lifelong disability from spinal cord, internal, and traumatic brain injuries and other morbidities (Papachristos, Wildeman, & Roberto, 2015). Papachristos and colleagues' (2015) study demonstrates how gunshot injuries are associated with substantial reductions in life expectancy, sometimes as much as 151-days for White males and nearly a year (362-days) for Black males (see also Lemaire, 2005). Gunshot injuries contribute to diminishment in overall quality of life and chronic illness (Papachristos et al., 2015).

Similarly, Lee's (2012) ethnography found that gunshot survivors in Philadelphia experienced injuries such as physical disfigurement and disability, severe depression and anxiety, as well as loss of employment. Additionally, victims with abdomen gunshot wounds were often unable to perform sexually and basic bodily functions such as regulating and controlling defecation. Fifty-percent of interview participants experienced excessive pain, stress, and anxiety caused by bullets or bullet fragments internally imbedded (Lee, 2012). Similarly, Gaw and Zonfrillo (2016) examined U.S. emergency department visits for non-fatal head trauma (N=207,159) and found that aggravated assault (95.9%) was the most common predictor of severe injuries to the head/skull.

Violence-related injuries vary in severity and impact and often involve hospitalization, high-risk surgeries, and premature death (Bazarian et al., 2005; Faul, Xu, Wald, & Coronado, 2010; Gaw & Zonfrillo, 2016). Such injuries and resultant health consequences can cause decreased quality of life across the lifespan or permanent harm to collective well-being and financial stability and solvency. Lee (2012) found that the negative effects of violence-related injuries interfered with individuals' ability to work and engage in and enjoy personal life.

Violence-related injuries can also be economically devastating and erode the economic health and development of everyone living in the community (Slutkin et al., 2018; Tcherni, 2011). Those injured during violent acts and the people who love/care for them often experience distressing financial impacts involving medical/healthcare and court/attorney costs, amongst others (Lugo & Przybylski, 2018). Research demonstrates that those injured by violence and their support networks experience higher insurance rates and lost works days that may disadvantage their own and their families' financial self-sufficiency and security long-term (i.e., "I won't ever catch up") (Lugo & Przybylski, 2018).

Papachristos et al. (2015) argue that the true costs of violence-related injuries greatly exceed the cost of estimates associated with aggregated assault and homicide data. The total estimated aggregate cost of police-reported crime to victims and society is $200 billion ($310 billion for unreported crime) and primarily attributable to murder and aggravated assault[3] (Chalfin, 2015). Although an astounding figure, the tangible costs to victims and their families such as property losses, medical/mental health care (e.g., chronic illness, disability care), lost work hours, as well as intangible costs such as pain, mental health trauma symptomology, decreased mobility and functioning, substantial life altercations, etc., although difficult to

[3]Nationally, murder accounts for 38% and assault accounts for 32.8% of the aggregate cost of crime (e.g., property losses, medical care, mental health care, productivity, criminal justice intervention) (Chalfin, 2015).

estimate, are much more substantial (Chalfin, 2015). Such costs intensify long-term individual- and community-level financial and personal harm thus compounding emotional stress and anxiety leading to mental health problems or worsening physical health conditions (McCollister et al., 2011). Such scholarship collectively suggests that violence-prevention programs must consider the role of public health within high violence areas.

Treating Violence as a Contagious Disease: Effective Programs

Basic and Direct Violence-Prevention Approach: Chicago's Cure Violence Model

Dr. Slutkin developed the Chicago-based Cure Violence Model (formerly the Chicago Ceasefire Model) at the University of Illinois at Chicago in support of the empirically-based contention that violence is like an epidemic disease, spreading contagiously from person-to-person and infiltrating communities (Delgado et al., 2017; Picard-Frische & Cerniglia, 2013; Skogan et al., 2009; Slutkin, 2013; Slutkin et al., 2018; Webster et al., 2012). The Cure Violence Model runs anti-violence initiatives in at least 25 cities in eight countries (Cure Violence Global, 2019), and has been analyzed – favorably – by scholars and clinicians. Cure Violence takes a holistic approach to violence prevention in that it addresses the total effects of violence in communities, how crime and violence destabilize communities economically, and emphasizes quality of life and the mental health and psychological effects violence can have on communities and residents (Cure Violence Global, 2019). Cure Violence implements its public health strategy in violent neighborhoods and works with community-integrated and based organizations to address the complex risk factors that elevate violence risk (e.g., unemployment, housing assistance, medical care, etc.) (Cure Violence Global, 2020). Taking a public-health driven approach and based on the value of collective efficacy, the Cure Violence Model contains five core components, including:

1. **Detecting potentially violent events and interrupting them** to prevent violence through trained "credible messengers," which includes identifying situations that can lead to violent acts and responding to shooting victims by comforting them and their families and advising against retaliation.
2. **Providing ongoing behavior change and support** to the highest-risk individuals through credible messengers. This work includes ongoing personal connections with at-risk youth to help them develop "plans of action" that help them identify high-risk situations and work to avoid or acting on violent urges.
3. **Changing community norms** that "allow, encourage, and exacerbate violence in chronically violent neighborhoods to healthy norms that reject the use of violence" (p. 2). This is done through a range of public education efforts and communications, organizing public meetings to promote anti-violence goals, and partnering with clergy, schools, courts, and other community entities.
4. **Ongoing data analysis** of past crimes and acts of violence that monitors and helps ensure proper implementation of anti-violence and anti-retaliatory urges and efforts. This community-wide approach requires constant monitoring of community conditions that have unwittingly contributed to violence and thus serves as a preventative intervention.
5. **Providing "training and technical assistance** to workers, program managers, and implementing agencies" (Cure Violence Global, 2019, p. 2) to address and teach the skills needed to bring about decreases in violence.

The Credible Messenger Movement and Approach. Credible messenger mentoring is an approach to decreasing youth recidivism among high-risk and justice-involved youth by training and employing community member mentors who have often formerly been involved in

the justice system. Credible messengers, individuals who have been incarcerated and have reentered their communities and transformed their lives, serve as mentors for justice-involved individuals at the highest risk of repeat criminal behavior (Credible Messengers Justice Center, n.d., Para. 5). The Credible Messenger movement holds that communities contain resources able to "lift up justice-impacted people in a comprehensive and positive way" (Credible Messengers Justice Center, n.d., Para. 1). Credible messenger mentoring is a peer mentoring model that uses a restorative justice and community care-based approach (Lopez-Humpreys, 2018). The restorative justice approach of the credible messenger mentoring model is designed to encourage those victimized by crime and violence to avoid retaliating with additional violence and instead encourages building positive relationships and "identity change" (Lopez-Humphreys & Teater, 2019b). This briefing summarizes the approach, its history, its role in violence prevention activities, and examples of the model's successes in multiple American cities.

History. Mentoring programs, including programs that use the Credible Messenger Model, evolved in greater numbers beginning in the 1990s. The War on Drugs and other enforcement measures led to a dramatic increase in the population of incarcerated individuals, disproportionately African American men from marginalized, disinvested communities throughout the U.S. (Hinton, 2016). These measures have created a need for government-sponsored rehabilitation programs for the formerly incarcerated. Prison overcrowding and high rates of recidivism have illuminated the need for alternative solutions to incarceration and traditional probation and parole methods. Municipal departments of justice have started paying more attention to mentoring programs as a solution to crime and recidivism since incarceration has been shown to be both costly and ineffective (Austria & Peterson, 2017).

Nine million individuals annually leave prisons or jails to return to their communities (U.S. Department of Justice, 2015). Approximately five million of those adults released from prison must participate in some form of community-based supervision (Lopez-Humphreys & Teater, 2019b). Mentoring programs have emerged as one tactic for reintegrating formerly incarcerated people into society. As mentoring programs demonstrated their value, some leaders saw promise in supporting through public funding mentoring and peer-based initiatives to prevent crime and recidivism. In 1992, Congress recognized the value of mentoring as a tool to "reduce delinquent activity" when it expanded the Juvenile Justice and Delinquency Prevention Act to provide funding for mentoring interventions (Lopez-Humphreys & Teater, 2019b).

In the three decades since Congress endorsed mentoring programs, mentoring programs increasingly have been recognized as effective interventions for addressing high-risk youth. Many programs that match at-risk youths with formerly incarcerated adults as mentors have demonstrated their effectiveness in preventing violence among youth and helping restore communities racked by violence (Credible Messengers Justice Center, n.d.). Some, such as the Cure Violence model and Arches have been recognized for implementing holistic programs that see individual growth and development as a process (National Research Council, 2008). Although not a replacement for more traditional programs such as probation, credible messenger mentoring programs can provide important support for social workers and other professionals who serve justice-involved individuals (Austria & Peterson, 2017)

Credible messenger mentoring programs, in particular the Cure Violence model, view violence as "an epidemic and public health issue…seek[ing] to interrupt the transmission of violence from offender to victim, and to make violence unacceptable…" (Credible Messenger, 2017). This "whole justice approach" invests in the "transformative resources" of communities

and their residents, particularly previously incarcerated "returned citizens," to share their experiences and serve as role models in preventing at-risk and high-risk youth from turning to violence (Credible Messengers Justice Center, n.d.). The next section discusses the Credible Messenger Model in detail.

The Credible Messenger Model. The Credible Messenger approach, with its emphasis on mentors who have experienced similar struggles to those who are in the program, is comparable to other peer support programs like Alcoholics Anonymous and those organized during and after the Vietnam War to help veterans return to their communities (Austria & Peterson, 2017). The term credible messenger was coined by Eddie Ellis, a former Black Panther (Austria & Peterson, 2017). Ellis taught and mentored fellow prisoners while incarcerated in a New York State prison in the 1980 when he coined the term "credible messenger" while teaching and mentoring fellow prisoners (Austria & Peterson, 2017). Ellis saw the potential of formerly incarcerated individuals returning to their communities to help young people avoid violence and prison and help restore their communities in the process. Moreover, Ellis and others pushed back against the larger policy approach of investing in prisons and incarceration at the expense of community-based programs. Inspired by Ellis, the credible messenger approach "provides a positive path for justice-involved people" (Credible Messengers Justice Center, n.d., Para. 3).

The Credible Messenger Model is considered an "inside-out" approach that employs individual mentors who share backgrounds and experiences of at-risk youth. The unique value and credibility of these individuals, according to the Credible Messenger (2017) is that they are

> credible because of the community being served, they can relate to high-risk individuals, are respected by high-risk individuals and have the ability to engage, connect, and empathize with them…in most cases, credible messengers have a personal history of street and justice-system involvement and are therefore seen as having 'been there and done that' with regard to the activities of at-risk youth.

Although credible messengers commonly have personal experience with the criminal justice system, credible messengers need not have been incarcerated to fulfill these duties to at-risk youth (Austria & Peterson, 2017). However, credible messengers must understand and relate to the pressures at-risk youth face and how incarceration affects individuals, particularly as these relate to the unique circumstances in their home communities. They also must be invested in their community and to provide "a link to the community and... [serving as] role models for the prosocial lifestyle that forms the heart of secondary desistance" (Gilbert & Elley, 2015, p. 18).

Credible messengers form meaningful relationships with mentees by gaining the trust of at-risk youth and modeling success. The credible messenger approach for many is "desistance in practice" (Buck, 2016, p. 3), where mentors provide a "useful and needed role" not only in coaching youth out of reoffending, which may lead to recidivism, but also "assist[ing] with personal recovery" of the youth they mentor. The model is, as Lopez-Humphreys and Teater (2019b) suggested, designed to make mentors "generative" actors (p. 19), who have "empathic impact in the lives of youth like themselves" (p. 14).

Applications of the Credible Messenger Model. Based on the premise that communities and their residents possess "transformative resources" to help those involved in the justice system (Credible Messengers Justice Center, n.d.), the credible messenger approach aims to improve outcomes for young people in the justice system and at risk of committing an offense that could put them in the justice system in five ways:

- Increased engagement with community-based programs and services
- Reduction in re-arrest, violations, and anti-social behaviors
- Increased compliance with court mandates
- Improved relationships between system stakeholders and community members
- Greater community capacity to support justice system-involved youth.

As part of building this community capacity to support youth, credible messenger programs affirm that public safety and public health improve when recidivism declines and young people in mentoring return to school, receive job training, and assume other positive roles that keep them away from violence/victimization. Advocates argue that the relationships built with government and service agencies (including police) through the strengths-based model also can advance the overall health and safety of the community (Austria & Peterson, 2017).

In addition to serving youth in these ways, a core attribute of credible messenger programs speaks to the sense of purpose in and among mentors. Through mentoring, credible messengers learn and master personal and professional skills that can contribute to their career development and employment opportunities. Credible messengers also build networks of peers with similar experiences that can have long-lasting, significant effects. These "group-based mentoring" relationships, Austria and Peterson (2017) argued, provide "an antidote for the burnout common in social services" (p. 1) programs and deepen mentors' personal commitment to their own transformation and growth.

Several programs have implemented the credible messenger approach, including the Cure Violence Model based in Chicago, Arches Transformative Mentoring Program in New York City, Ten Point Coalition in Boston, Alliance of Concerned Men in Washington, DC, The Mentoring Center in Oakland, and others. The Cure Violence Epidemic Control Model (Cure Violence Global, 2019), which has served as a foundation for many other credible messenger-based programs, is a "data-driven, research-based, community centric approach to violence prevention" that frames violence not as endemic to communities or individuals but as a "learned behavior and can be prevented using a disease-management approach" (p. 1).

The Cure Violence Credible Messenger Model has also been applied in hospitals through the creation of hospital-based violence intervention programs (HVIPs). Like credible messenger mentors, “Violence Intervention Specialists” (VIS) used their lived experience directly in hospitals/trauma centers in one Maryland-based study to promote anti-violence and anti-retaliation approaches for young Black men being treated for wounds suffered from violence (Wical, et al., 2020). This HVIP, unique for its “patient-centered outcomes approach” found lacking in most hospital-based trauma response programs, was overseen by trained VISs who worked with 116 youth victims of violence (Wical et al., 2020, p. 68). Of those, only one returned with a violent injury in the next 17 months. That one percent trauma recidivism rate contrasted with a 32 percent rate before the violence intervention program, demonstrating that a mentor-based approach in this setting “may be a viable means to reduce rates of firearm-related trauma recidivism” (Wical et al., 2020, p. 68).

A related New York City initiative, Arches, employs the Credible Messenger Model. Launched in 2012 with funding from then-Mayor Michael Bloomberg’s philanthropic foundation, the program matched credible messengers with young people on probation aged 16 to 24 (Credible Messengers Justice Center, n.d.). The mentors were very much like the youth with whom they were matched, selected for their ability to “support development of robust relationships with program participants that are built upon authentic shared experiences and understanding” (Credible Messengers Justice Center, n.d., Para. 10). Working in small group mentoring and one-to-one formats, mentors engaged directly with youth deemed “hardest to reach” (Credible Messengers Justice Center, n.d.). A detailed impact evaluation of the program determined that mentor-mentee relationships were particularly solid and close due both to mentors’ round-the-clock availability and their shared experiences with the youth they served.

The evaluators also found significantly lower recidivist conviction rates for youth in the program, two-thirds lower than a control group of youth parolees (Urban Institute, 2018).

The Credible Messenger Model has offered youth and the communities in which they live alternatives to violence and hope for avoiding recidivist violence and its worst effects. Employed in multiple urban environments, the approach has demonstrated its strong and enduring value in advancing and maintaining "ongoing non-recidivating behavior," while helping contribute to declining rates of violence and recidivism among high-risk youth.

Violence Spreads Like Contagious/Epidemic Infectious Disease. Infectious disease epidemics and violence have many similarities (see Slutkin, 2013; Slutkin et al., 2018). Deaths due to violence are at an epidemic proportion similar to deaths by, for example, COVID-19, cancer, and narcotic overdoses (Hickner, 2018; Murphy, Kochanek, Xu, & Heron, 2015; Rudd et al., 2016). Violence like disease has particular symptoms that cause morbidity and death; and violence like contagious epidemics involves transmission and replication across varying sized geographic areas and differing social groups (Slutkin, 2013; Slutkin et al., 2018). Not everyone exposed to contagious processes such as violence/disease will demonstrate the "medical ailment" of violent behavior. Other factors influence the adoption of violet behaviors such as poverty, poor education, residential instability, racism, family structure, exclusion, and segregation depending on proximity, age, dose, and context (Ransford & Slutkin, 2017; Slutkin, Ransford, & Decker, 2015; Slutkin et al. 2018). For example, research reveals that Blacks and Latinos report less tolerance of violence and crime than other racial/ethnic groups, however, the impact of such is blunted by fewer mechanisms present within poor communities to facilitate enacting their values (Sampson & Jeglum-Bartusch, 1998). While such structural factors are important causal mechanisms of violence, Cure Violence prioritizes enhancing public health, changing individual

behaviors, and shifting group norms to stop people from being murdered, which in turn helps to reduce other community-level structural problems that contribute to violence (Cure Violence Global, 2020; Slutkin et al., 2018). Such goals are realized through opening violence-discouraging pathways to community-enhancement (e.g., employment and housing assistance), opportunities, and alternatives to violence (Slutkin et al., 2018).

The strongest predictor of violence, like disease epidemics, is past exposure (Papachristos et al., 2015; Slutkin, 2013; Slutkin et al., 2018). Exposure to violence operates to heighten individuals' susceptibility to pronounced violent behaviors within their communities (Slutkin et al., 2018). Research reveals that the risk of chronic violent behavior is 30 times greater when a person is violently victimized or observes violence (Slutkin et al., 2018; Spano, Rivera, & Bolland, 2010). Infection risk increases with close contact to individuals with contagious diseases like tuberculosis (Comstock, 1982). Likewise, the risk of violent victimization significantly increases when people are exposed to violence-prone peers (Papachristos et al., 2015) and are living in communities where violence is normalized. High levels of violence within communities are inextricably linked to elevated levels of violent victimization wherein many individuals (especially youth) feel pressure to subscribe to cultural pressure and norms promoting violence in order to ensure survival (Alleyne & Wood, 2014; Walters, 2018). Due to the normalization of violence within these communities, when these individuals do not respond to conflict with violent behavior, the victimization is likely to persist endangering the safety of themselves and/or their families (Alleyne & Wood, 2014; Walters, 2018).

Spread through exposure, violence imbeds itself in the brain, body, and social processes (Hickner, 2018; Slutkin et al., 2018). Violent victimization or visual exposure to violence initiates the contagion process in the brain where it learns, develops scripts, copies behaviors,

becomes accustomed to, attempts to meet conscious and unconscious social expectations, and thus normalizes violence (similar to how the intestines facilitate transmission of cholera for example) (Slutkin et al., 2018). In this way, people develop adaptive responses that are situationally specific, including aggression, impulsivity, depression, stress, hypersensitivity, and changed neurochemistry (Ransford & Slutkin, 2017; Slutkin et al., 2018). Violence mirroring the individual's previous violent exposure is thus reproduced and transmitted to other persons(s) or groups depending on the context of varying street-level interactions (Slutkin et al., 2018).

Additionally, both disease and violence involve geo-temporal and person-to-person transmission and spreads and clusters in particular geographic areas and among certain groups of people (Bingenheimer, Brennan, & Earls, 2005; Kaufman & Zigler, 1987; Slutkin, 2013; Slutkin et al., 2018; Spano et al., 2010; Towers, Gomez-Lievano, Khan, Mubayi, & Castillo-Chavez, 2015). Both disease epidemics and violence epidemics go through incubation periods where there is a delay between infection and disease evidence (Slutkin et al., 2018). Incubation periods for both similarly share great variation ranging from days/weeks to years (Slutkin et al., 2018). For example, incubation periods for cholera, like riots, gang wars, or genocide, can be rapid (Slutkin et al., 2018; Verwimp, 2004), or more delayed in tuberculosis, like family or community violence (Slutkin et al., 2018). Several studies have revealed that violent offenders who were exposed to child abuse or family violence did not perpetrate similar violence until many years or decades into adulthood (Ehrensaft et al., 2003; Kalaitzaki, 2019; Huesmann, Moise-Titus, Podolski, & Eron, 2003; Slutkin et al., 2018).

Stopping the Spread of Violence. The Cure Violence method conceptualizes preventing violence through addressing/controlling its disease-like characteristics (Slutkin et al., 2018). Cure Violence identifies and maps high transmission areas, reaches out to individuals exposed,

and intervenes to reduce future spread and risk factors such as retaliatory violence often associated with gang-related deaths (Cure Violence Global, 2020; Slutkin, 2013; Slutkin et al., 2018). The process of interrupting violence involves preventing retaliatory violence (particularly shootings), mediating ongoing conflicts, and regular follow-up to keep the conflicts tempered (Dymnicki, Henry, Quintana, Wisnieski, & Kane, 2013; Slutkin et al., 2006). Cure Violence also focuses on changing the perceptions of those at highest risk of perpetrating and transmitting violence throughout the community, as well as changing social-level violence-supportive group attitudes and norms (Cure Violence Global, 2020). The program thus collectively operates to "vaccinate" violence at the individual-, relationship-, community-, and social-levels of the socio-ecological model (CDC, 2020; Cure Violence Global, 2020; Slutkin, 2013).

Carefully designed enrollment criteria exist to identify, recruit, and treat those young men at highest risk of violence perpetration (Butts, Gouvis Roman, Bostwick, & Porter, 2015). Participants recruited to receive treatment and program benefits must align with at least four of seven criteria: (1) involved in gang activity, (2) leadership or major role in a drug or street organization, (3) record of violent criminality; (4) recently incarcerated, (5) gun carrying street reputation, (6) recent gun shooting victimization, and/or (7) aged 16-25 years (Butts et al., 2015).

Butts and colleagues (2015) describe how Cure Violence staff implement the program to effectively prevent violence transmission. Highly-trained community-level organizers known as **"violence interrupters"** personally engage recruited participants to change their violent behaviors and norms. Violence interrupters are credible messengers who utilize direct intervention to stop violent incidents in communities and are hired for their extensive knowledge of crime and violence through personal experiences with both, which allows them to establish trusting, informed relationships with young men who are at highest risk of violence. Violence

interrupters are carefully selected as they must be perceived as credible insiders/messengers among community members at highest risk of violence perpetration. They ideally come from the communities in which they work and are often former high-level gang members or respected on the streets and recognize the extensive personal harm that can come from criminal justice involvement/incarceration and have thus chosen to change the direction of their lives. Such personal experiences of street-level violence lend these practitioners knowledge about how people engaged in criminal lifestyles live their daily lives. Violence interrupters' behaviors and high-risk community members perceptions must align for the Cure Violence strategy to work as intended. That is, violence interrupters are trained to not demonstrate judgement or inform police, and cannot be perceived by high-risk young men as potentially engaging in either behavior. Separate from traditional criminal justice crime deterrence strategies, the Cure Violence model does not threaten punishment or force participation, nor use law enforcement to meet its goals. It is guided by the principle that violent behavior (like all behavior) responds to structures, incentives, and norms, and offers at-risk individuals non-violent conflict resolution strategies, similar to. It functions both independently of police and to not undermine their crime-control efforts. The model seeks to work in alignment with police for a more comprehensive and successful approach to mitigating violence.

Friends and associates of loved ones shot or injured during violent altercations often desire to seek revenge (Butts et al., 2015). Thus, violence interrupters form relationships with young people at highest-risk of violent behavior to gain knowledge of and monitor ongoing conflicts in order to avert potential violent retaliation before it occurs (Butts et al., 2015). Violence interrupters seek out the victim's known associates and try to discourage their retaliatory motivations (i.e., talk them down) or convince them that they can employ techniques

other than violence to negotiate the conflict and avoid risking death or their freedom, as well as inflicting and perpetuating community-level harm (Butts et al., 2015).

Cure Violence prioritizes identifying and treating those at highest risk of violent behavior and concurrently operates to instill norms focused on resisting and preventing violence at the community-level (Butts et al., 2015; Cure Violence Global, 2020; Slutkin, 2013). Consequently, the program serves to address the contagious nature and pervasive harms of violence (Butts et al., 2015; Cure Violence Global, 2020; Slutkin, 2013). Violence interrupters serve as role models to those they mentor because they personify attitudes and personal conduct that demonstrates the possibility of both obeying the law and being respected by community members (Butts et al., 2015). Violence interrupters demonstrate how program participants can engage in anti-violence advocacy and become leaders in growing a violence free community/society and enhancing the lives of their loved ones and neighbors (Butts et al., 2015).

Outreach workers are similar to case managers serve another key role within the Cure Violence framework (Butts et al., 2015). Similar to violence interrupters, outreach workers need to develop trusting relationships with, and be seen as credible messengers by, individuals highly prone to violence in neighborhoods, and are often recruited based on their prior criminal justice system involvement (Butts et al., 2015). However, unlike violence interrupters, outreach workers apply knowledge gained from building strong relationships and simultaneous needs assessment. As a result of this process, outreach workers connect participants with community-level positive opportunities such as jobs, education, and resources (e.g., housing assistance, social services, and recreational activities) (Butts et al., 2015). Outreach workers facilitate pathways to opportunities and resources to guide potentially violent community residents to change their beliefs about violence and correspondingly alter their behavior.

Effective Collaboration Fosters Elevated Violence-Prevention Success. The Cure Violence model involves extensive collaboration and frequent case analysis to facilitate effective violence-prevention outcomes (Butts et al., 2015). Regular and sometimes daily meetings are held where violence interrupters and outreach workers compare notes on their interactions with participants at greatest risk of violence, and work in tandem with their supervisors and program directors to review and discuss strategies embedded in program and participant interests and needs (Butts et al., 2015). During these case planning sessions, all employees' observations are recorded and organized in a continually updated database that protects the confidentiality of participants (e.g., pseudonyms are typically used such as Person A, Person B) (Butts et al., 2015). Confidentiality is a central tenet of the Cure Violence model as it fosters trust among participants that their criminal involvement will not be reported to the police or to gang members, which increases the likelihood of their continued cooperation and safety (Butts et al., 2015). In so doing, staff collectively operate to match as many participants as possible with responsive resources and opportunities to extract them from violent lifestyles (Butts et al., 2015).

Violence interrupters and outreach workers also work collaboratively with neighborhood partners to achieve the Cure Violence core component of changing social norms (Butts et al., 2015). Such goals are realized through activities like targeted media campaigns, signs and billboards, public anti-violence marches, and shooting victim vigils (Butts et al., 2015). The intervention's social change efforts work to expose community members (directly and indirectly affected by violence) to anti-violence messaging that embeds a general anti-violence social consensus (Butts et al., 2015). The program reaches out to religious organizations, neighborhood associations, tenant councils, and other organizations to further encourage community-level support and collective engagement in violence-prevention efforts (Butts et al., 2015). Cure

Violence staff also work with law enforcement to gain strategic information on crime patterns, and involve officers in the hiring of violence interrupters and outreach workers.

Measuring the Effectiveness of Cure Violence. The most comprehensive evaluation of Slutkin's Chicago Cure Violence model was conducted by Skogan and colleagues (2009) under a DOJ-funded research grant. The scholars examined both the effectiveness of the program's processes at 13 sites, and shootings and retaliatory killings outcomes across 7 primary evaluation sites. Evaluation of process components involved conducting interviews with 300 program staff and 297 clients to document the program's operation in the high-violence communities it served (e.g., staffing, training, and management practices). The outcome evaluation statistically examined crime hot spot maps and analyses of gang networks to determine the program's influence on shootings and murders (across the 7 primary evaluation sites). Matched comparisons of changes in violence outcomes pre-program introduction and post-program implementation were also completed.

Skogan et al. (2009) used 16 years of historical shooting data and found that in those communities with the Cure Violence program, shootings were reduced by 41%-73%, as well as decreased shootings in "hot spots" of up to 40%. Further, 87% of clients targeted for individual attention in the program, almost all of them considered high-risk, received the resources they needed to prevent violence. Crime map analysis showed declines in the size and intensity of heavy/hot spot shooting and gang involvement within the communities where Cure Violence was based. The program was also linked to an up to 100% decrease in retaliatory homicides across the 7 sites over a 1-7-year period. Overall, study results were mixed indicating positive changes in some of the Cure Violence neighborhoods, but not in others (Butts et al., 2015; Skogan et al.,

2009). The findings across sites varied widely, but the study design did not incorporate measures to assess causal factors for such variation (Skogan et al., 2009).

Additionally, process evaluation interviews found that the majority of Cure Violence participants believed the program was “very important” in their lives. They were especially satisfied with violence interrupters who helped them to diffuse violent confrontations that typically result in retaliatory shootings. Violence interrupters were perceived as operating effectively across geographic boundaries to identify developing conflicts that would have been missed focusing only on individual communities. Most program staff (violence interrupters and outreach workers) felt prepared to conduct field work due to effective training (90%) and case planning meetings (85%). The majority of outreach workers also reported that they successfully connected clients to job training programs (72%) and interviews (64%) at least once a month. Similarly, program participants who received such services were twice as likely as others who did not to have found a job (Skogan et al., 2009).

In a later study, Henry, Knoblauch, and Sigurvinsdottir (2014) used police crime data (homicides, shootings, and battery) to examine Cure Violence’s effectiveness in reducing criminal violence in two South side Chicago police districts – District 3, Woodlawn (2 police beats), and District 10, North Lawndale (2 police beats). Woodlawn and North Lawndale have historically maintained alarmingly high levels of homicide, shootings, and other violent crime. The City of Chicago funded the Cure Violence intervention in these districts, and the scholars analyzed violent crime data between the start of the intervention in September 2010 and the end of the intervention in September 2013. Raw crime counts showed that post-intervention, there was a 31% reduction in homicides, a 7% reduction in total violent crime, and a 19% decrease in shootings within the targeted districts. Such declines were consistent throughout the intervention

period in each district. During the study time period, crime was decreasing overall in Chicago; however, the effects of the intervention had a greater impact than this general decline. Neighborhoods with the Cure Violence intervention demonstrated a 38% greater decline in homicides, 1% larger reduction in total violent crime, and 15% greater decrease in shootings than control neighborhoods without the program. Results were also somewhat mixed as to effectiveness where post-implementation of Cure Violence, the Woodlawn neighborhood showed a significant decrease in the violent crime rate of change, however the North Lawndale neighborhood did not. The scholars surmised that such differences may be associated with Cure Violence employing different violence-prevention strategies in each district – one that involved gang leaders in conflict negotiations in Woodlawn, and one that involved traditional Cure Violence methods in North Lawndale.

Similarly, following implementation of Cure Violence in Woodlawn and North Lawndale, Gorman-Smith and Cosey-Gay (2014) used interview methods to explore the impact of the program on neighborhood residents (n=35) and clients (n=40, 20 high-risk Cure Violence clients and 20 high-risk individuals who were not clients). Cure Violence participants reported that program mentoring and employment services reduced their involvement in crime/violence. Participants also indicated that violence interrupters were effective at mediating neighborhood conflict because they were perceived as highly credible (“the things they did, I did”), which encouraged people to listen and respect their message.

Results also revealed that program staff were successful at educating their target audience (i.e., violence-involved youth and youth at high risk of violence) about the program, but did not have a similar impact among community residents. Ninety-eight percent of high-risk individuals involved and not involved in Cure Violence had knowledge about the program compared to 34%

of community residents (Gorman-Smith & Cosey-Gay, 2014). Residents widely reported negative perceptions of and experiences with law enforcement, however saw police as the only useful option to address persisting violence in their communities (Gorman-Smith & Cosey-Gay, 2014). Such results suggest that more intensive Cure Violence community mobilization efforts may position the program as a useful resource to address community-level violence.

Similar reductions in violent crime associated with the Cure Violence model can be found in the other states such as Philadelphia, PA ("Philadelphia CeaseFire") (30% decline in the rate of shootings; Roman, Klein, & Wolff, 2017) and New Orleans, LA ("NOLA FOR LIFE") (18% lower murder rate; City of New Orleans, 2016). The Cure Violence approach has also been demonstrated efficacy at preventing violence across the globe, including in Mexico (24% reduction first year followed by a 13% decline second year; Del Barrio a la Comunidad, 2016; Mesa de Seguridad y Justicia de Ciudad Juarez, 2019 [see Cure Violence Global, 2020]), Honduras (88% reduction in killings; Roman et al., 2017), Trinidad (45% violent crime decrease; Maguire, Oakley, & Corsaro, 2018 [see Cure Violence Global, 2020]), Puerto Rico (50% reduction in killings; Nina, 2013 [see Cure Violence Global, 2020]), the United Kingdom (38% decline in violent incidents and 95% reduction in group attacks; Ransford, 2017 [see Cure Violence Global, 2020]), and South Africa (53% reduction in shootings and 31% decline in killings; Ransford, 2016 [see Cure Violence Global, 2020]).

Safe Streets, Baltimore, MD. Between 2007 and 2009, the Baltimore City Health Department replicated the Cure Violence model under the name, "Safe Streets" in four of Baltimore's most violent neighborhoods engaging hundreds of high-risk youth. Unlike the standardized Chicago Cure Violence model, Safe Streets does not use both violence interrupters and outreach workers; rather, it employs hybrid outreach workers that perform both roles.

Webster et al. (2012) analyzed homicide and nonfatal shooting police data from 2003-2010 to assess the effects of Safe Streets on violent crime, as well as interviewed program participants (n=32) about their perspectives of the program's usefulness in their lives.[4] The scholars compared changes in the number of homicides and nonfatal shootings per month in neighborhoods where Safe Streets was implemented with high violence comparison communities. Findings indicate that Safe Streets was significantly associated with large reductions in gun violence in 3 of the 4 neighborhoods. The program affected a 56% reduction in homicides, a 34% decline in nonfatal shootings in the Cherry Hill neighborhood, and a 26% decrease in homicides in McElderry Park. The study also revealed a 34% decline in nonfatal shootings within the Elwood Park community, however, the result was not statistically significant. Collectively, such results were related to high levels of staff mediation of conflicts. In a study using the same data, Webster, Whitehill, Vernick, and Curriero (2012) controlled for several measures of police activity and baseline levels of homicide, and found that Safe Streets implementation was associated with an approximate reduction of 35 nonfatal shootings and at least 5 homicides across 112 months in four of Baltimore's most violent neighborhoods. Such results were evident almost immediately after program implementation.

Studies have also examined the attitudes and perspectives of Safe Streets program staff to measure the violence-prevention effectiveness of the program. For example, Webster et al.'s (2012) study revealed that between 2007 and 2010, hybrid outreach workers mediated 276 incidents of violence. Safe Streets workers believed they successfully *fully* resolved conflicts in 69% of cases, and *temporarily* resolved conflicts in 23% of cases. Similarly, Whitehill, Webster, Frattaroli, and Parker (2013) conducted focus groups with 24 Safe Streets hybrid outreach

[4] This study also included interviews with community residents about their opinions of gun violence. Program participants' perspectives were highlighted to assess the effectiveness of the program.

workers and interviews with 8 Safe Streets program managers in 3 high-violence East Baltimore neighborhoods (i.e., McElderry Park, Ellwood Park, and Madison-Eastend) and the South Baltimore Cherry Hill neighborhood. Successful mediation of violent conflicts was perceived to be associated with strong outreach worker-client relationships and utilization of conflict mediation strategies, including separating the likely shooter from the intended victim and violence-prone peers, and then convincing all involved to use peaceful conflict resolution strategies such as returning stolen property and highlighting how violence leads to terrible consequences (e.g., jail, death, police investigation).

Additionally, the Safe Streets intervention focuses on changing at-risk youth's attitudes about gun violence and providing positive alternatives and education to stop violent behavior and promote anti-violence community-level advocacy. Webster et al.'s (2012) interview results showed that 80% of high-risk youth participating in Safe Streets believed that their lives were "better" due to the program and that it was important in their lives. Their perspectives were based on productive meetings with their outreach workers 3 or more times a week for job assistance, job interviewing skills and job/trades training, enrolling in a school or a GED program, and resolving conflicts with family members. Similarly, Milam and colleagues (2016) used quantitative methods to investigate perceived norms and perspectives of gun violence as a mechanism to resolve conflict among 478 young people (18-24-years old) at high risk of mortality and morbidity in two analogous high-violence Baltimore neighborhoods. Attitudes were measured 1-year prior and 1-year post-Safe Streets intervention implementation. Findings showed a statistically significant 43% improvement in anti-gun violence attitudes post-intervention versus 13% in the control community (i.e., where Safe Streets was not present). When compared to the control community, participants also demonstrated statistically significant

improvement in opinions toward peaceful conflict resolution versus violent conflict resolution. Program participants who were exposed to Safe Streets interventions such as "stop shooting" signs and outreach workers nearby showed non-violent attitudes toward conflict.

Coordinated and Wrap Around Violence-Prevention Approach: New York's Crisis Management System

New York City's "Crisis Management System" (CMS) was launched in 2010 (with funding from the U.S. DOJ) to replicate the Chicago Cure Violence model, and has expanded to 21 high-violence precincts across the city. The CMS expands the Cure Violence model to incorporate an established network of wrap around support services (i.e., school conflict mediation, employment programs, therapeutic mental health services, legal services, and an Anti-Gun Violence Employment Program) (NYC Office to Prevent Gun Violence, 2020). Similar to Safe Streets, the CMS deploys hybrid violence interrupters and outreach workers known as "credible messengers" to mediate street-level conflicts and connect high-risk residents to wrap around resources that can help them to avoid violence long-term (NYC Office to Prevent Gun Violence, 2020). Wrap around services for CMS participants include: (1) *school conflict mediation*, which provides culturally competent, school-wide activities and services to at-risk youth to both change the culture around violence and increase social measures such as attendance and academic progress (NYC Office to Prevent Gun Violence, 2020); (2) an *employment program* known as "Justice Plus" that offers work readiness training and services such as work experience placements, job skills development, job search, and career awareness/planning, as well as a financial stipend; (3) culturally competent *therapeutic mental health services* supporting children, youth, and families impacted by gun violence to assist in improving resilience, developing responsive support networks, and building self-management/self-care skills; (4) *legal services* (and representation as needed) provided by Legal

Aid Society that help at-risk individuals address legal emergencies and substantive legal issues such as criminal law, housing, family, employment issues, post-conviction planning, etc.; and (5) the *Anti-Gun Violence Employment Program (AGVEP)* that offers a 6-week summer and a 25-week school year employment to program participants ages 14-24 (NYC Office to Prevent Gun Violence, 2020). Participants perform job responsibilities such as canvassing communities, mapping assets, collecting data/research, community outreach, and coordinating/conducting responses to shootings (NYC Office to Prevent Gun Violence, 2020). Such responsibilities are targeted toward developing anti-violence attitudes (NYC Office to Prevent Gun Violence, 2020). As part of the CMS approach, credible messengers' methods consistently interact and overlap with supportive wrap around services addressing key risk factors for violent behavior to provide a more comprehensive and individually-tailored approach to violence-prevention.

Research on the effectiveness of CMS in preventing violence has primarily been conducted by the John Jay College of Criminal Justice Research and Evaluation Center in New York City. Across 29-months, Picard-Fritsche and Cerniglia (2013) evaluated the impact of the CMS replication of Cure Violence in Crown Heights, NY known as, "Save Our Streets" (S.O.S.). The Crown Heights S.O.S. employed four credible messengers (carrying caseloads of 5-15 participants) that recruited 96 high-risk (68%) and medium-risk (18%) participants based on age, educational or employment problems, prior justice-system involvement, and gang activity. The majority of participants were Black or West Indian and between the ages of 15-26. Across the study period, hybrid credible messengers mediated over 100 potentially violent street conflicts involving more than 1,000 individuals. The S.O.S. program organized 43 community events and 50 shooting vigils that attracted an estimated 6,000+ residents, and distributed more than 5,000 anti-violence educational materials throughout the borough. Anonymous surveys of Crown

Heights residents (N=100) were conducted early on post-full S.O.S. implementation (Wave I, 3-months) and after extended time had passed post-implementation (Wave II, 16-months later). Results revealed that 73% of residents had a high-level of awareness of the S.O.S. campaign at Wave II compared to 27% of residents at Wave 1. Residents indicated that they had strong confidence in the S.O.S. campaign's mobilization efforts to reduce gun violence in their communities – i.e., at Wave II, 55% of respondents were "very likely" to have such confidence compared to 29% at Wave I. Residents were much more likely to believe the S.O.S. program was effective if they had participated in its community events. At the same time, survey results indicated that the S.O.S. intervention did not increase feelings of safety among or change residents' perspectives about the legitimacy of carrying guns or joining a gang. Fifty-six percent of respondents exposed to violence through seeing someone threatened or shot with a gun supported the legitimacy of carrying a firearm to protect themselves, compared to 35% of residents who had not witnessed violence. Respondents who had seen violence were 31% more likely to support joining a gang when compared to 23% of those who had not witnessed violence. Such findings may speak to the socially entrenched nature of violence within disadvantaged communities requiring long-term and sustained Cure Violence community-level programming.

Picard-Fritsche and Cerniglia (2013) also compared gun violence statistical data in Crown Heights where the S.O.S. intervention was implemented to a matched comparison group of 3 adjacent police precincts (Brownsville, East Flatbush, and parts of Bedford-Stuyvesant) without the intervention 18 months pre- and 21-months post- S.O.S. implementation. Results showed that within S.O.S. Crown Heights communities, shooting rates decreased by 6% and increased between 18% and 28% in the three matched areas. It is important to note that post-implementation of S.O.S., monthly gun violence shooting rates increased by nearly 20% in

surrounding comparison precincts, and no new policing initiatives or violence-prevention programs (other than S.O.S.) targeting gun violence crime control were implemented in the Crown Heights target area. The study demonstrated that if Crown Heights were to mirror the upward trend in gun violence in the comparison precincts, its gun violence rates would still be 20% lower due to effective S.O.S violence-prevention efforts. That is, decreases in gun violence in Crown Heights were not associated with violent crime displacement to adjacent precincts, and can be directly attributed to the S.O.S. intervention.

Within the South Bronx (program known as "Save Our Streets" [S.O.S.]) and East New York, Brooklyn (program known as "Man Up! Alpha") boroughs, Delgado et al. (2017) visited program sites, interviewed credible messengers, analyzed violence crime data, and surveyed young men living in 12 neighborhoods with and without the CMS program. Findings showed that CMS participants' willingness to use violence declined 33% between 2014 and 2016 compared to a 12% decline among non-CMS participants. These results support Milam et al.'s (2016) findings that Cure Violence is associated with positive changes in participants' violence-supportive attitudes. The CMS had an especially strong effect on shifting participants' pro-violence conflict resolution attitudes toward pro-peaceful conflict resolution attitudes in petty disputes (a less strong effect on serious disputes). Such findings may suggest that Cure Violence is effective at reducing less serious disputes before they become serious and potentially lethal in nature, which could effectively reduce gun violence in affected communities across time. Using the same study-level data (Delgado et al., 2017), Butts and Delgado (2017) similarly found that community residents' confidence in and willingness to call the police to respond to violence in CMS areas increased 22% compared to 14% in comparison areas without the program.

Delgado et al.'s (2017) analysis of shooting victimizations and gun injuries data between 2012 and 2016 revealed that rates of firearm injury in the CMS East New York area dropped by 50% compared to a 5% decline in the matched comparison non-CMS East New York area (Flatbush). The South Bronx area served by Cure Violence showed an impressive 37% decline in gun injuries and 63% reduction in shooting victimizations compared with 29% and 17% decreases in the matched comparison areas within East Harlem. Other factors such as law enforcement intervention and varying social services programs can contribute to these reductions, however, the study controlled for numerous important explanatory variables and still found a strong and significant influence of the program on community-level violence.

All-Encompassing Violence-Prevention Approach: 414Life – Blueprint for Peace (Milwaukee, WI)

A unique violence-prevention program known as "Milwaukee Blueprint for Peace: 414Life" was designed between 2017 and 2019 and is currently in process of implementing its multitude of program elements across Milwaukee communities. In November 2019, 414Life implemented a violence-prevention strategy replicating the Cure Violence model in two neighborhoods (Old North Milwaukee and Garden Homes) with historically high levels of violent crime (City of Milwaukee, 2020). Given the newness of the program, no evaluation studies have yet been conducted. The program is more comprehensive than the other two models detailed above and takes violence-prevention a step further. 414Life seeks to reduce violent crime such as homicide, shootings, and aggravated assault like the other programs; however also intends to diminish other forms of violence such as domestic violence, sexual assault, and child maltreatment as well as address their underlying causes.

The Blueprint is a long-term investment program involving an all-encompassing, coordinated strategy for preventing both interpersonal *and* structural violence. The types of

interpersonal community-level violence targeted include simple assaults, aggravated assaults, nonfatal shootings, homicides, and sexual and domestic violence, gun and gang violence, and child maltreatment; and the types of *structural community-level violence* targeted include racial violence, police violence, mass incarceration, and drug-related violence (City of Milwaukee, 2020). Creation and current implementation of the 414Life initiative has incorporated diverse feedback from a multitude of community leaders, residents, and youth, as well as knowledge from evidence-based violence-prevention programs across the country (e.g., Cure Violence and CMS) (City of Milwaukee, 2020). The intervention's primary goals are to (1) stop shooting and thus stop violence, (2) promote healing and restorative justice, (3) provide support to children, youth, and families, (4) further economic opportunity, (5) create safe and strong neighborhoods, and (6) strengthen the capacity and coordination of city-level government institutions and non-profit social services agencies to prevent violence (City of Milwaukee, 2020).

Similar to other violence-prevention programs reviewed above, 414Life's approach operates separately from and in partnership with the criminal justice system's (Milwaukee Police Department, Milwaukee County Circuit Courts, and Juvenile Corrections) enforcement and suppression crime control strategies (City of Milwaukee, 2020). These legal entities are essential to providing field-level data, information, and expertise to 414Life on violence occurring in Milwaukee communities and the factors influencing contact with and containment within the justice system (City of Milwaukee, 2020). The 414Life intervention is guided by the premise that no violence-prevention effort can be effective alone; rather, balanced collaboration between 414Life, the criminal justice system, and local assets (e.g., non-profit social services agencies, mental health services) is essential to providing youth, families, and communities with safety and justice (City of Milwaukee, 2020). 414Life's balanced and coordinated approach to developing

prevention, intervention, enforcement, and reentry strategies help to reduce violence and increase the safety and health of communities (City of Milwaukee, 2020). 414Life partners share a unifying vision and overarching, "all hands-on deck," method to violence-prevention that seeks to address the underlying factors contributing to violence, build on assets and culture within communities, and apply data systematically to ensure effective solutions (City of Milwaukee, 2020). The 414Life blueprint has been designed with flexibility in mind wherein it will be reviewed and modified annually (10 years forecasted, but plans for future sustainment) depending on the context of violent crime occurring in Milwaukee's most hard-hit neighborhoods (City of Milwaukee, 2020).

Unique to other violence-prevention programs in the U.S., 414Life is designed to also reduce structural oppression (City of Milwaukee, 2020). Milwaukee is the 5th most impoverished city in the nation with a poverty rate of 29%, which is double the state's poverty rate (City of Milwaukee, 2020). 414Life seeks to address the relationship between violence and neighborhood environment to simultaneously improve the health, well-being, and resilience of community residents and reduce violent crime (City of Milwaukee, 2020).

To achieve its collective violence-prevention goals, 414Life is working to implement its comprehensive strategy through (1) *leadership and oversight* from Milwaukee city government entities and local-government partner; (2) *violence prevention council establishment* to guide implementation and monitor progress; (3) *capacity-building and alignment* across violence-prevention sectors through ongoing education, training, and technical assistance, as well as utilization of healing and restorative justice approaches to strengthening youth and families where possible; (4) *tailored communication strategies* development focused on informing marginalized and priority populations about violence as a public health issue, improving shared

understanding of violence prevention, and promoting commitment to peace; (5) applying an equity lens to implement 414Life in 10 target neighborhoods across time that are disproportionately impacted by concentrated poverty and violence; as well as school and youth engagement and federal, state, and local violence- and equity-building policy development, among other strategies (City of Milwaukee, 2020).

Deterrence-Based Prevention Models

Other methods to prevent violence focus on reducing criminal recidivism after adult and juvenile offenders have been convicted and incarcerated or are subject to community corrections such as probation, mandatory supervised release, or parole. Such deterrence methods include counseling, discipline, multiple coordinated services, restorative programs, skills building, and surveillance (Clark, 2010). For example, the cognitive behavioral therapy (CBT) recidivism-reduction approach has been widely used in the criminal justice system since the late 20th century, and seeks to help offenders become conscious of their thought patterns about crime and violence, and thus change the way they think about both so they can alter their behaviors in a more positive direction (Clark, 2010). More specifically, crime perpetrators often develop thoughts and behaviors favoring violence due to direct exposure to criminal offending and/or victimization, however they may not be certain why they think and act in these ways. In this context, violence feels normal and correct. As a result, they may respond to conflict and stress within their lives with violent behavior and continue doing so because they are not conscious of the root cause of their violent inclinations. CBT seeks to help offenders become aware of their thought processes to disrupt this damaging cyclical process. The model works within criminal justice institutions such as prisons, and community corrections settings such as probation and parole (Clark, 2010). CBT teaches men who use violence how to improve their social and

problem-solving skills (absent violence), critical thinking, moral reasoning, self-control, and impulse management (Clark, 2010).

Lipsey (2009) conducted a meta-analysis of 548 studies comparing the effectiveness of recidivism-reduction strategies, including counseling, deterrence, discipline, restorative programs, and skill building. He found that punishment and deterrence-based models (such as Operation Ceasefire described below) were associated with increases in criminal recidivism, while therapeutic approaches involving counseling, skill building, and multiple services were associated with reductions in criminal recidivism. In an examination of varying therapeutic models, he also found that CBT skill building programs were more effective at reducing reoffending than any other intervention type. Similarly, Landenberger an Lipsey's (2005) meta-analysis evaluated the efficacy of CBT programs within prison, residential, community probation, and parole settings and found that CBT significantly reduced recidivism among all types of offenders – low-risk, medium-risk, and high-risk.

However, research shows that results are too mixed or there is not enough research demonstrating the wide-scale efficacy of CBT programs in reducing criminal recidivism. Feucht and Holt (2016) examined 50 CBT programs and 8 practices across the nation to evaluate their effectiveness in decreasing criminal reoffending, and uncovered that CBT is more effective with juveniles than adults. Such results may be associated with adults having more engrained maladaptive thoughts that are difficult to alter. Across the majority of programs, CBT was effective at helping offenders manage trauma. However, Freucht and Holt (2016) found that 12% of the 50 programs demonstrated "no effects" and 14% offered "insufficient evidence" of effectiveness. A lack of pronounced effectiveness may be associated with a lack of incentive to change behavior within criminal justice settings. Additionally, returning citizens leaving

correctional control often return to communities where violence is normalized and individual-level CBT is no designed to change community-wide, violence-supportive norms.

Another approach to curbing urban violence is known as focused deterrence, most popularly referred to as “Operation Ceasefire.” Operation Ceasefire has been used in Boston, Chicago, Cincinnati, Indianapolis, New Orleans, Oakland, and Los Angeles and involves coordination between the criminal justice system, community residents, and local non-profit and government social services agencies. Operation Ceasefire staff (police officers, state prosecutors, academics, social service providers, outreach workers, and/or Black clergyman) work to identify people at highest risk of perpetrating or being a victim of gun violence within highly violent neighborhoods (Clark, 2010). Each Operation Ceasefire program uses a slightly modified approach to identifying program participants. For example, in Minneapolis, police analyzed data on 264 murders and matched victims and offenders against a gang database to identify people necessitating intervention (Clark, 2010). Upon identification, individuals are called and asked to attend “call ins” or meetings with police, probation, parole, clergy, community members, and close, trusted relatives (Clark, 2010). Program staff warn participants that the police know about their criminality and that they will be severely punished if they do not stop committing crime. In coordination with these warnings, program staff provide services such as life coaches, housing, jobs, health insurance, and ongoing counseling (Clark, 2010). Operation Ceasefire seeks to find the most dangerous people and groups in society, warn them of impending punishment, crackdown on crime, spread the message to other potential offenders, and reinforce such crime control through useful services provision and community support (Clark, 2010).

A Department of Justice pre-post evaluation study of the Boston Operation Ceasefire program revealed that violence among youth dropped by 75% two years following

implementation and Boston maintained these rates for five years (Braga, Kennedy, Piehl, & Waring, 2001). Braga, Zimmerman, Brunson, and Papachristos (2018) examined shootings data between 2011 and 2017, pre- and post-implementation of the Oakland, CA Operation Ceasefire intervention. The scholars found that shootings dropped by 50% across the 6-year time period. Operation Ceasefire was also directly associated with a 32% decline in gun homicides even after controlling for factors such as gentrification and seasonal patterns (Braga et al., 2018). While such outcomes are notable, states have regularly dropped the program, in part because police officers have been dissatisfied with only applying a problem-solving approach to crime prevention rather than traditional policing methods (McGarrell, 2020). Additionally, Operation Ceasefire has demonstrated mixed results, showing only short-term violence-reducing effects, but such outcomes typically decay within two years or levels of violence significantly increase (see Braga, Weisburd, & Turhcan, 2018; Fox & Novak, 2018). One could argue that a lack of success in this regard may be related to the intervention being punitive rather than reparative, having a lack of credibility due to being administered by police who are perceived as regularly inflicting individual- and community-level harm, and failing to address the embeddedness of violence within disadvantaged neighborhoods.

Conclusion

This literature review has examined three violence-prevention models embedded in the public health philosophy – Chicago's Cure Violence, New York City's CMS, and Milwaukee's Blueprint/414Life. Chicago's Cure Violence model has empirically demonstrated high-levels of effectiveness at reducing/preventing violence within some of the nation's most dangerous neighborhoods. Safe Streets utilizes the traditional Cure Violence model, however instead of using both violence interrupters and outreach workers, deploys hybrid outreach workers that

perform both roles. Both approaches have operated to successfully reduce/prevent violence. These programs each work at the street-level to identify and interrupt violence through mediating conflict; educating high-risk participants about its devastating harms and providing them with resources to diminish incentives for violent behavior; and change social norms through repetitive anti-violence community events.

New York's CMS also uses hybrid staff known as, "credible messengers," and expands the Cure Violence model through incorporating a comprehensive network of wrap around services and programs that target risk factors for violence such as mental illness and school-based conflict. These services operate in partnership with street-level efforts to "re-thread" the social fabric, changing the culture supportive of violence. Both Cure Violence and CMS also incorporate understanding that structural factors such as poverty, unemployment, and residential instability increase the risk of violence and position escaping or avoiding violent lifestyles as overwhelmingly challenging or unreachable. Thus, resources provision as part of both models also serves to minimize those structural concerns and advance violence alternatives long-term.

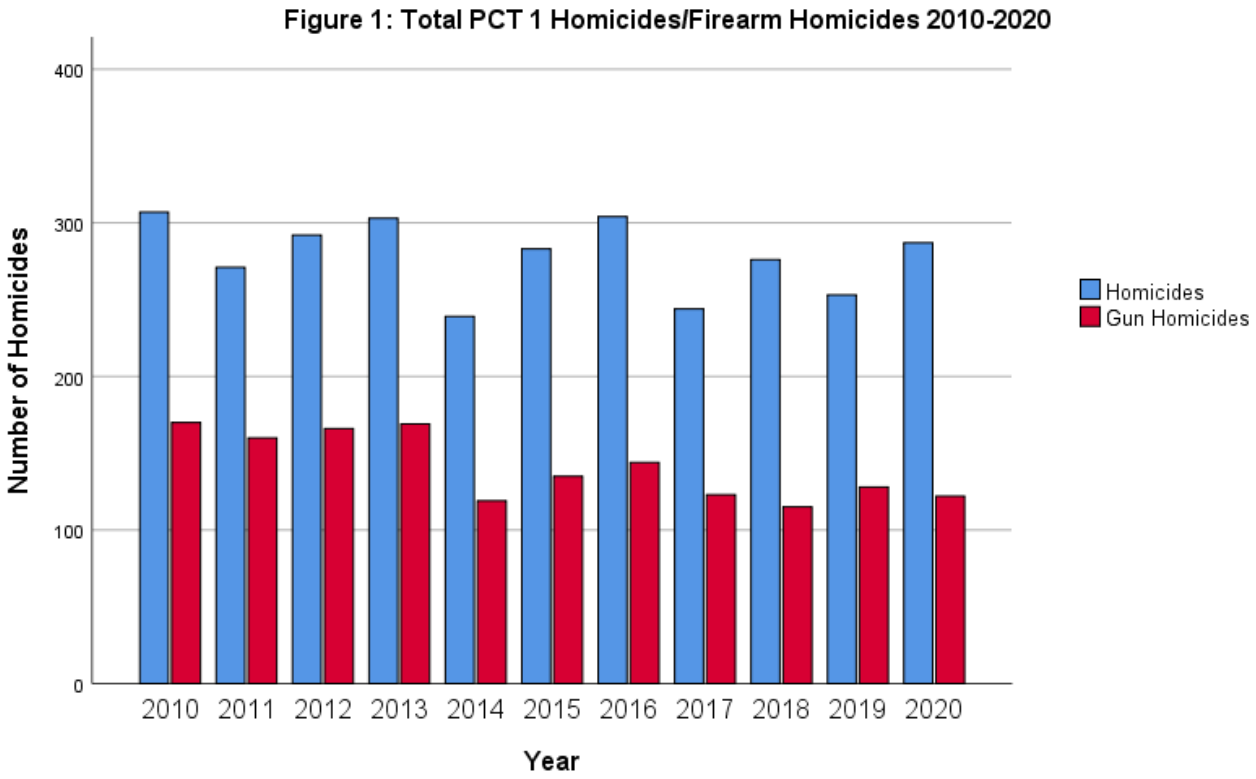
Finally, Milwaukee's 414Life model is a brand-new approach to violence-prevention that is currently being implemented. It uses the traditional Cure Violence model specific to violence interruption and services provision, however employs a more comprehensive approach targeting stopping/reducing a larger number of violent crimes, including sexual assault, domestic violence, and child maltreatment. The program is also intended to address racial and structural oppression that create the foundation for high levels of violence to occur. The Blueprint is designed to accomplish these objectives through establishing strong collaborative relationships between government, police, and social services invested in violence-prevention, coupled with broad and tailored services delivery and community activities to foster anti-violence attitudes.

Each model can be tailored to meet the violence-prevention needs of Harris County Precinct 1 and improve the health and happiness of residents. Harris County may want to consider the 414Life model in the future after it has successfully implemented the Cure Violence or CMS frameworks in some of its high-violence communities, or progressively building its chosen model across time to be responsive to changing conditions and enhance public health benefits. Harris County can design an innovative violence-prevention program unlike any other in the country that responds to immigration, unique cultural concerns and disadvantage within ethnically/racially concentrated communities, and structural factors contributing to crime. Collectively, implementation of such an approach is likely to enhance the resilience, health, and vitality of Harris County communities.

Neighborhoods with Disproportionately High-Levels of Homicide and Aggravated Assault: Considering Violence Prevention

Harris County, Precinct 1: Violent Crime Data Analysis

This report summarizes analyses of Harris County, Precinct 1 (Texas) violent crime data (i.e., homicides, gun violence, and aggravated assaults), and highlights particular communities statistically assessed as the "best fit" for violence prevention programs. As shown in *Figure 1*, between 2010 and 2020, murders decreased 6.5% in Houston. However, between 2019 and 2020, murders increased 13.4%, which may suggest an upward trend (pending analysis of future data). Homicides perpetrated with a firearm comprised 50.7% of all Precinct 1 murders between 2010 and 2020. *Figure 2* demonstrates that between 2010 and 2020, aggravated assaults maintained a steady upward trend, increasing by 122.3% over time. Similarly, *Figure 3* shows a varying declining-inclining trend in violent assaults perpetrated with a firearm, increasing 35.4% over the past 10 years (also a 59.2% increase between 2018 and 2020).



varying declining-inclining trend in violent assaults perpetrated with a firearm, increasing 35.4% over the past 10 years (also a 59.2% increase between 2018 and 2020).

Figure 2: Total PCT 1 Aggravated Assaults 2010-2020

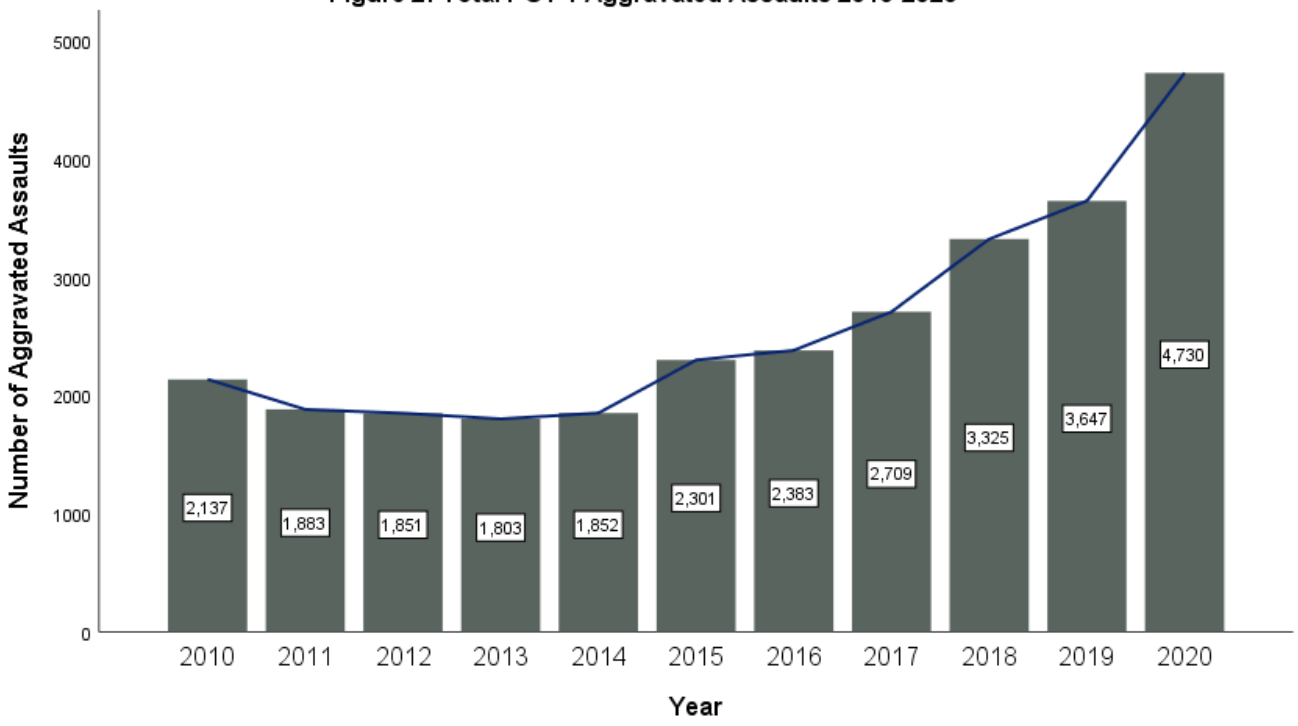
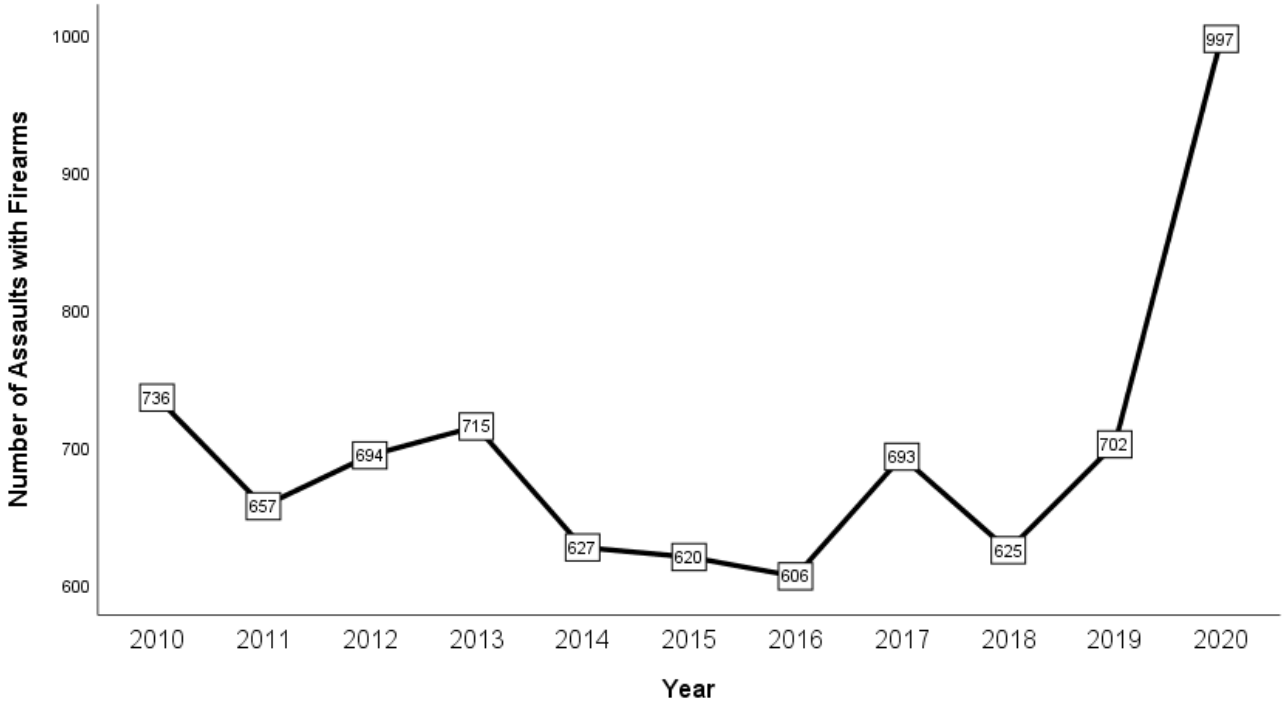


Figure 3: Total PCT 1 Assaults with Firearms 2010-2020



Looking Closely at Houston. Houston, Texas is unique when compared to other large cities in the United States. The city is the nation's most culturally diverse comprised of 45% Hispanic and 22.6% African American residents (U.S. Census Bureau, 2020). Additionally, 48.9% of the population speaks another language at home and 29.3% are foreign born (U.S. Census Bureau, 2020). Violent crime rates have historically remained high across time, affecting the health and well-being of Harris County residents. Houston's violent crime levels are 150% greater than the Texas average and 170% higher than the national average (Federal Bureau of Investigation [FBI], 2019). Most of this crime is concentrated in certain areas of Houston, three of which are detailed below and would benefit from violence prevention program intervention. These communities/areas – Sunnyside (Southside) (zip codes 77051 and South Park 77033)[5], Greater OST/South Union (Southside– zip code 77021), and Sharpstown (Southwest side – zip code 77036) – were statistically identified as having higher levels of *both* homicide and aggravated assault across time (2010-2020) when compared to other Precinct 1 areas.

Table 1 shows the top 10 communities identified through this analysis with recommendations for violence prevention program placement highlighted in medium blue. Additionally, two other communities – Acres Homes (zip code 77088) and Greater Third Ward (zip code 77004) – are also highlighted as equally well-suited for violence prevention efforts (light blue in Table). Using crime data spreadsheets provided by Harris County, the total counts for homicides were added together and the total counts for aggravated assaults were similarly summed from 2010 to 2020 within Precinct 1 zip codes. A list of high-count communities for each type of violence was compiled and longitudinal patterns of data were analyzed to narrow

[5] Sunnyside and South Park crime data were combined because these communities are often analyzed together by other scholars, directly neighbor each other, and thus likely share similar risk factors for violence.

Neighborhoods	Homicide Total	Aggravated Assault Total	Area of the City	Bordering/Neighboring Communities	Zip
Sunnyside/South Park	62	857	South	Greater OST	77051 / 77033
Cypress Station	61	573	North	Greenspoint	77090
Sharpstown	55	747	Southwest	Alief	77036
Greater OST/South Union	52	638	South	Sunnyside; Third Ward	77021
Greater Greenspoint	51	523	North	Cypress Station	77060
Acres Homes	47	702	Northwest	Greenspoint	77088
Greater Third Ward	41	510	Southeast	Greater OST	77004
Addicks Park Ten	41	372	Northwest	None	77084
Alief	38	347	Southwest	Sharpstown	77099
Eastex/Jensen	31	573	Northeast	None	77093

Table 1: *Total homicides and aggravated assaults from 2010-2020 in Houston communities. Medium blue indicates communities that are recommended for the pilot program, and light blue indicates other potential neighborhoods for consideration.*

down and compile an accurate list of communities with high levels of both crimes for violence prevention program focus/consideration.[6] Please note that the next step in the community selection process (working with Dr. Chico Tillmon) involves visiting high-violence communities and interviewing residents as well as asset mapping to determine which areas are most appropriate for violence prevention program implementation. Geospatial maps representing structural resources and concerns of selected neighborhoods may be more useful after this process is complete.

The Sunnyside, Greater OST/South Union, and Sharpstown Neighborhoods

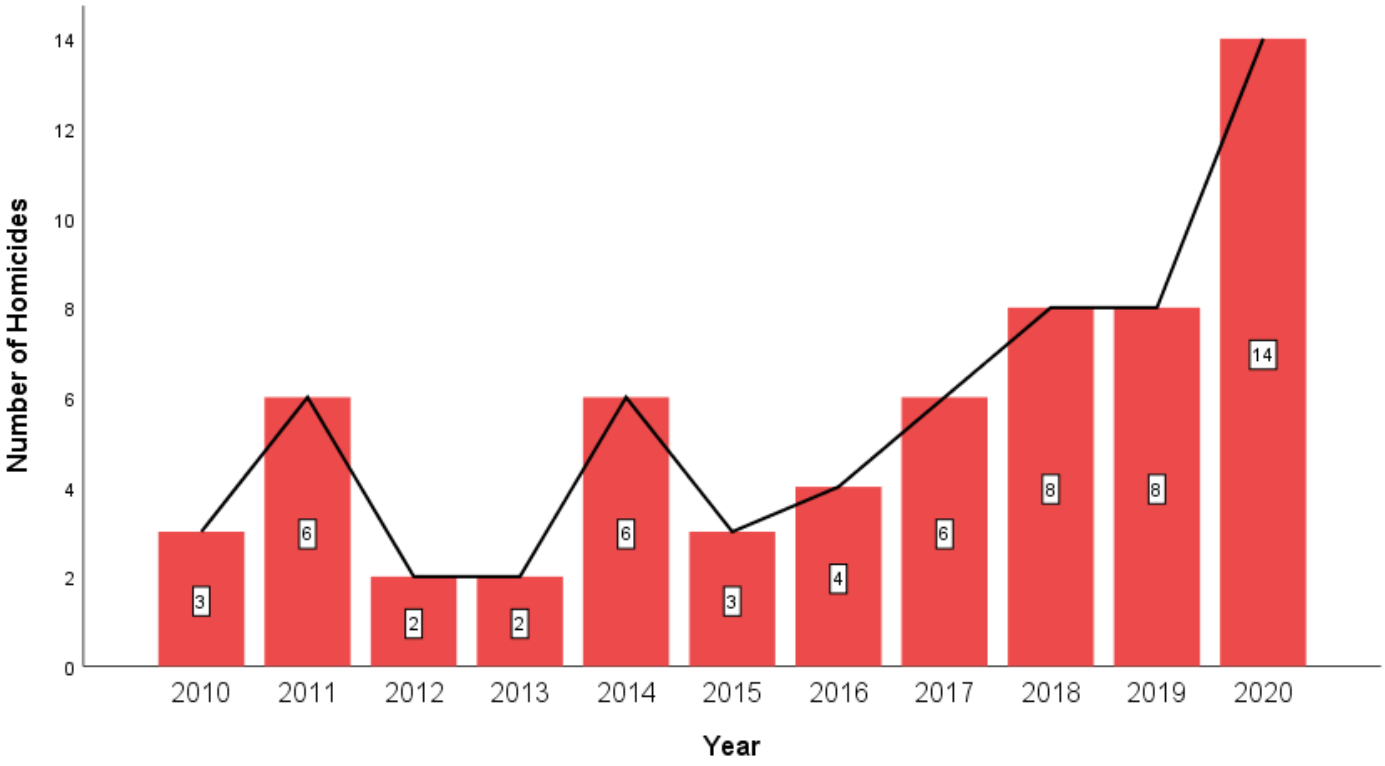
Sunnyside (includes the South Park community)

Throughout this report, Sunnyside (zip code 77051) and South Park (zip code 77033) are described as one community – "Sunnyside" – throughout this report because both neighbor each other and are typically considered one and the same in Houston due to similar characteristics, population demographics, and crime trends. Sunnyside and South Park are historically Black communities located South of downtown Houston. If Harris County Precinct 1 decides to focus on this area for the pilot violence prevention program, Tillmon Training & Consulting recommends that both communities are addressed simultaneously as part of the same program.

The violent crime rate per 1,000 people is 91.27, and residents have an annual 1 in 11 chance of being victimized (FBI, 2019). *Figure 4* shows homicides (N=62) within these communities between 2010 and 2020. The chart demonstrates an alarming 366.6% increase in total homicides across time. The most striking element of the chart is the steady, sizeable

[6] There are some inconsistencies across data sheets. For example, homicide and aggravated assault counts for years 2019 and 2020 in the 2010-2020 zip codes Excel spreadsheets are different from the homicide and aggravated assault counts for the years 2019 and 2020 in the 2019-2020 zip codes Excel spreadsheets. As a result, the 2019 and 2020 counts from each sheet were added together and averaged.

Figure 4: Sunnyside and South Park Total Homicides 2010-2020



increase in homicides between 2015 and 2020, as well as the 75.0% jump between 2018 and 2020. Specific to each individual neighborhood (*Figures 5* and *6*), it is clear that both communities share similar longitudinal patterns in homicide. As shown in *Figure 5*, Sunnyside demonstrates fluctuating and steep increases/decreases in homicides across time, which is problematic given the community never appears to stay in a downward or stabilizing trend for long before an increasing homicide pattern starts again. *Figure 6* for the South Park community indicates a similar pattern.

Sunnyside zip code 77051 has 17,139 residents and African Americans make up the majority of the population at 84.05% (Houston Health Department, 2020). Youth/adults ages 15-34 comprise 36.2% of the total population. The South Park community (zip code 77033) borders Sunnyside to the east and has a population of 29,233 residents, 66.4% of which is African

American[7], and approximately 28.8% of the population are age 15 to 34. Communities with high numbers of young/younger aged people tend to have elevated crime rates across time.

Figure 5: Sunnyside Total Homicides 2010-2020

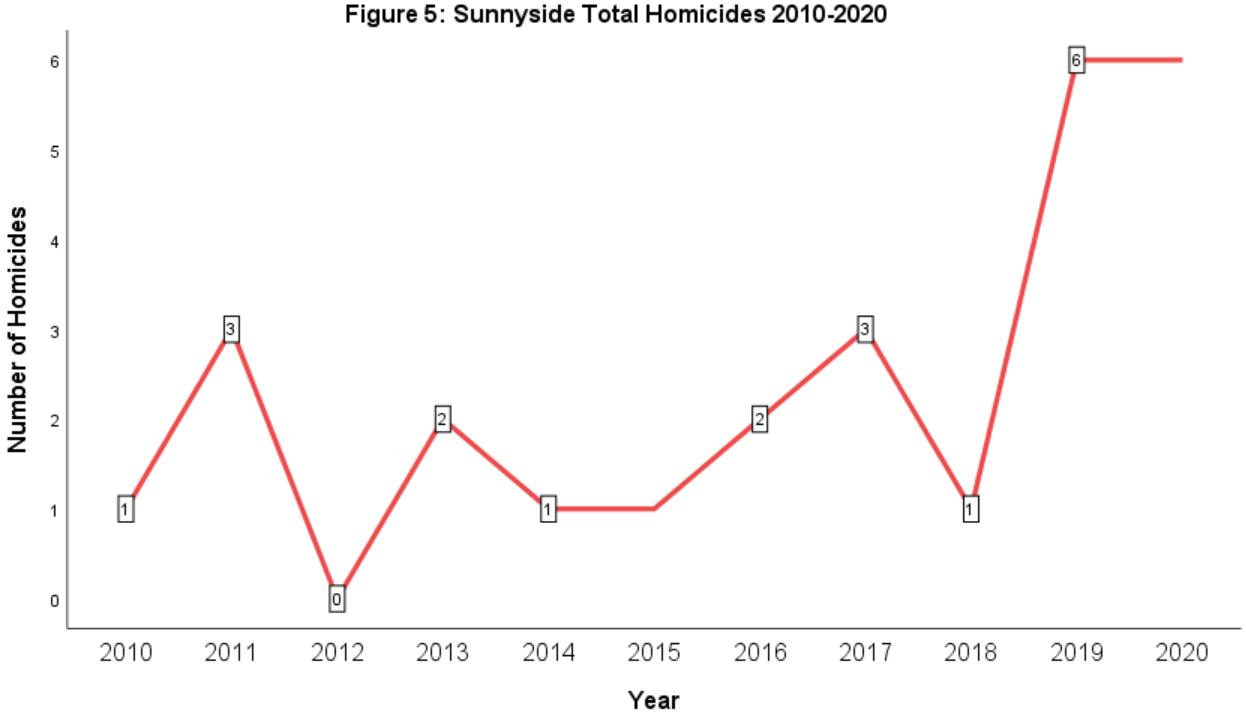
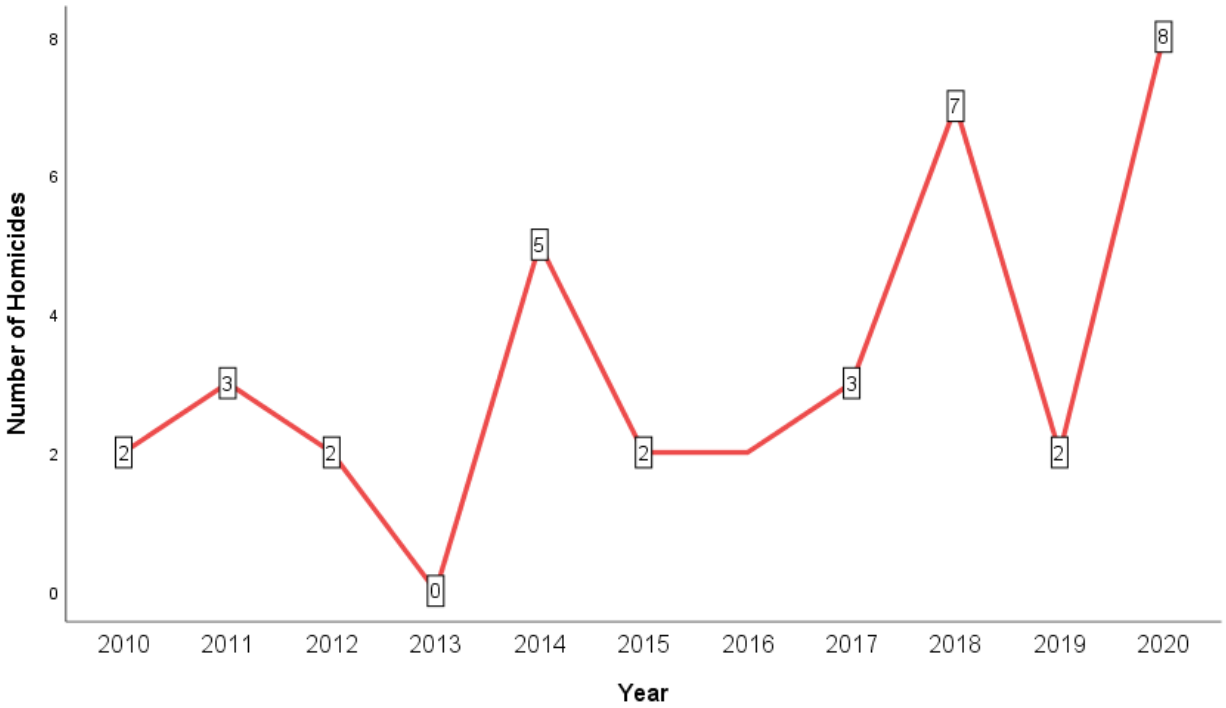


Figure 6: South Park Total Homicides 2010-2020



[7] People with Hispanic/Latino ethnicity comprise 31.81% of the overall population.

Additionally, as shown in *Table 2* (Houston Department of Public Health, 2020), both communities also experience alarmingly high structural and poor health stressors that deteriorate quality of life and thus contribute to high violence risk. Lack of access to gainful income and educational opportunities can detrimentally affect the health and vitality of community members harming their capacity to survive and thrive, which may influence higher criminality. A tailored violence prevention program to reduce the violence that consistently traumatizes Sunnyside and other similarly situated neighborhoods can help to reduce the perpetuation of violent behavior.

	SUNNYSIDE	SOUTH PARK
Structural Risk Factors		
Below poverty line	35.8%	28.0%
Bachelor's degree or higher	10.9%	8.1%
Food insecurity	46.7%	63.2%
Households that spend 30%+ income on rent	59.2%	60.1%
Poor Health Risk Factors		
High blood pressure	49.2%	46.7%
Insufficient sleep	48.1%	46.3%
Poor mental health	18.1%	17.0%
Obese	49.4%	47.8%

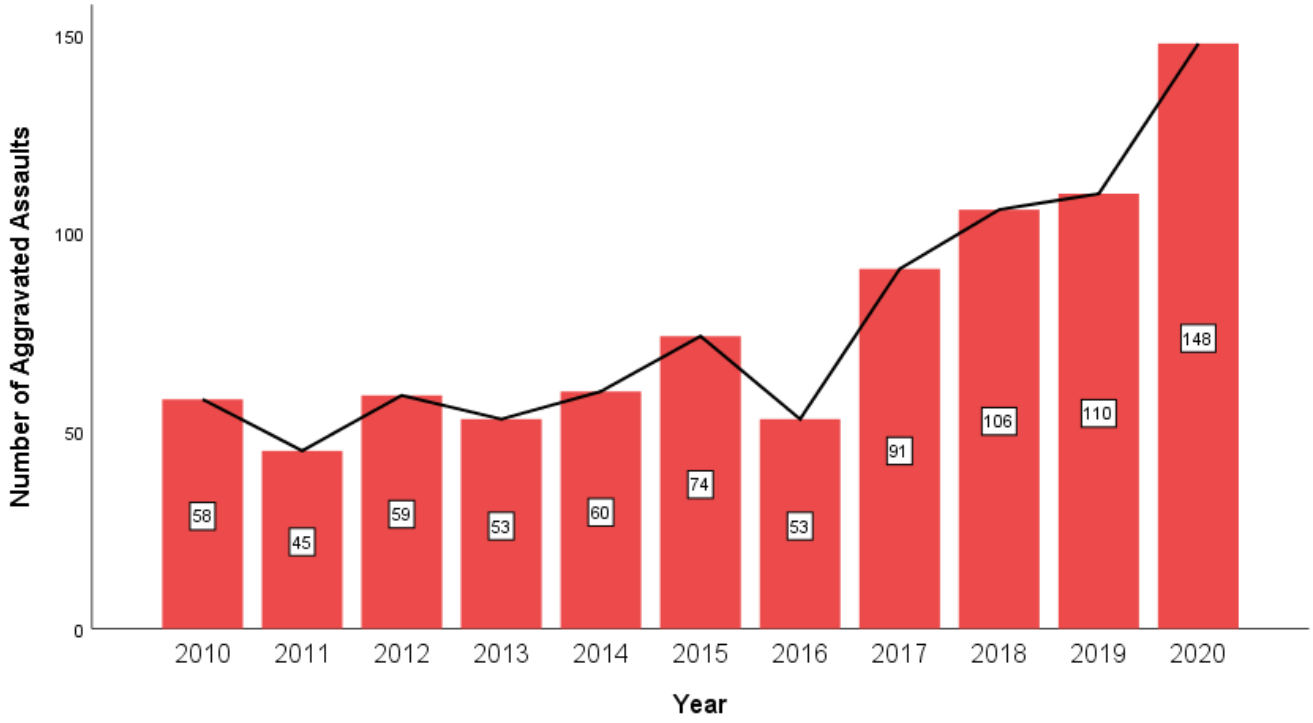
Table 2: *Community-level risk factors for violence in the Sunnyside and South Park communities.*

Aggregated data show that in the Sunnyside and South Park neighborhoods between 2010 and 2020, there were 857 aggravated assaults (see *Figure 7*). Aggravated assaults increased 155.1% across this time period. Disaggregating the data, both Sunnyside and South Park showed a similarly shaped longitudinal pattern with a 211.1% increase in aggravated assaults in Sunnyside and a 130.0% increase in South Park across the 10-year period.

Greater OST/South Union

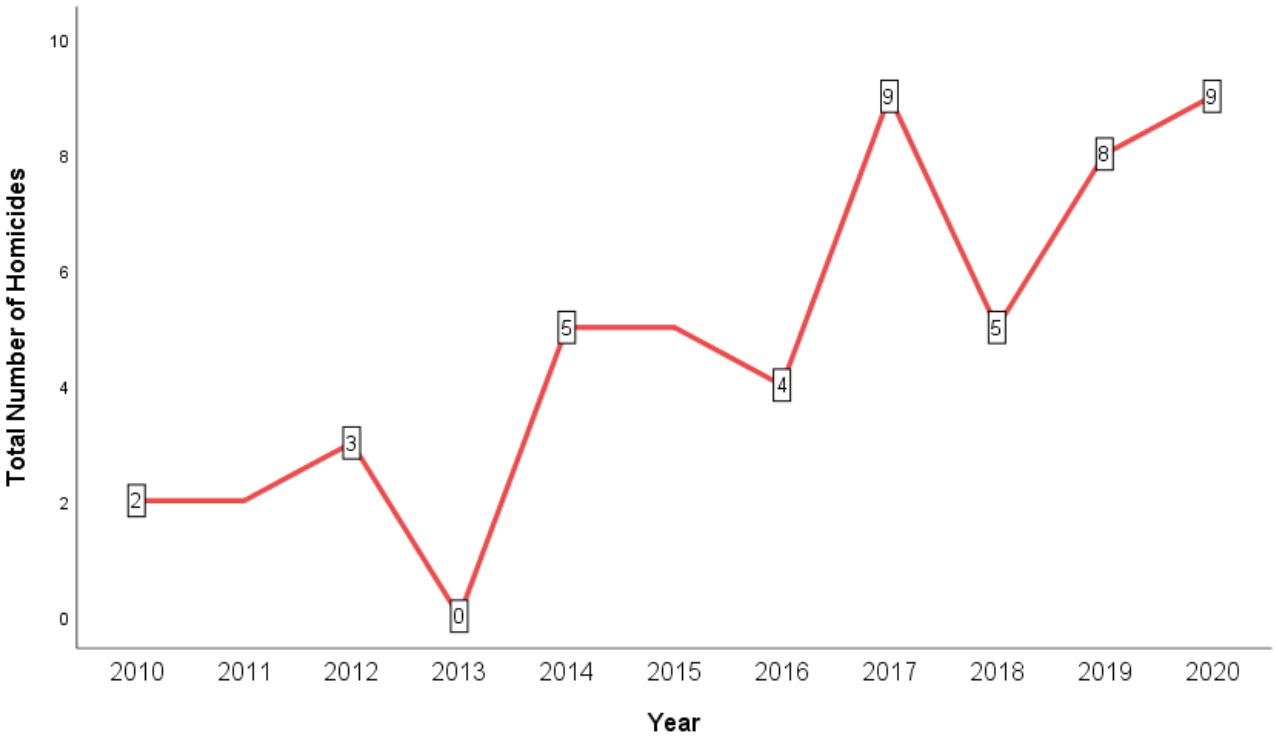
Greater OST/South Union (zip code 77021), also referred to as, "Yellowstone," is a historically Black community located on the Southside of Houston and has a population of

Figure 7: Sunnyside and South Park Total Aggravated Assaults 2010-2020



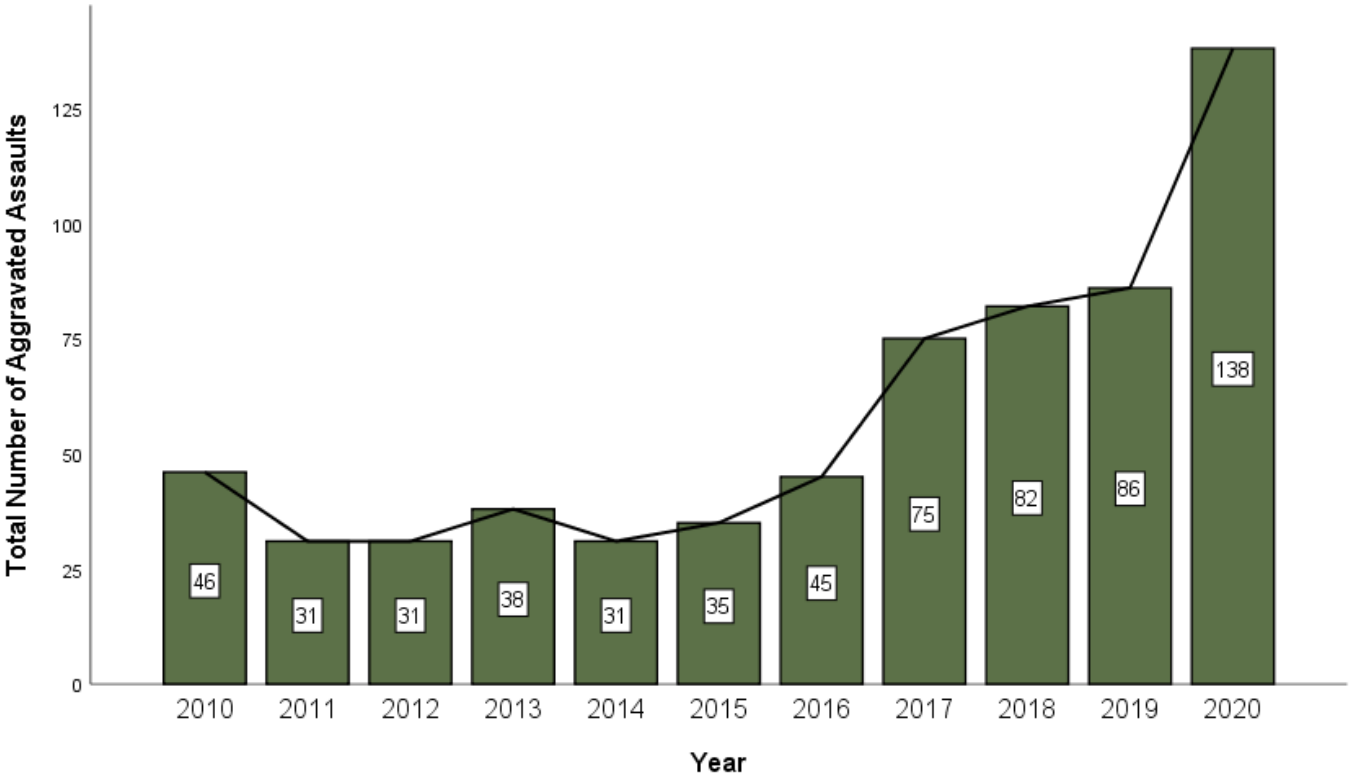
28,921 (Houston Health Department, 2020; U.S. Census Bureau, 2019). African American (71.5%) and Hispanic/Latino (19.6%) residents comprise a majority of the population (Houston Health Department, 2020; U.S. Census Bureau, 201 9). *Figure 8* shows the total number of homicides each year from 2010 to 2020 in Greater OST/South Union. Homicides alarmingly increased by 350% across the 10-year period, a percentage rise substantially higher than the majority of neighborhoods listed in Table 1. The neighborhood also demonstrates a uniquely irregular homicide trend across time that raises cause for concern. That is, decreases in lethal violence temporarily occur, appear to stabilize for a short time, and then soon thereafter increase, sometimes sharply, time and again. There was a large increase in homicides between 2013 and 2014 from 0 to 5, and since then, murders in the neighborhood have not remained consistently

Figure 8: Greater OST/South UnionTotal Homicides 2010-2020



stable, reduced markedly, or reached the low levels of 2010-2013. Fluctuations in homicide numbers may reflect changes in population density, economic conditions, and/or housing stability, amongst others, across time. While declines in murders are shown in the trajectory, such reductions are brief and numbers have progressively crept upward with counts reaching an all-time high of 9 in both 2017 and 2020. Additionally, murders in Yellowstone between 2018 and 2020 have increased by 80% and suggest an ongoing rising trend (pending analysis of 2021+ crime data) without the vacillation demonstrated in previous years. Irregularity in the trajectory suggests potentially chaotic changes in neighborhood structural conditions, which may compound stress, anxiety, and poor health outcomes among residents across time. *Figure 9* shows the longitudinal pattern of aggravated assaults in Greater OST/South Union between 2010 to 2020 with a dramatic 200% increase between 2010 and 2020.

Figure 9: Greater OST/South Union Total Aggravated Assaults 2010-2020



Structural and community health data further reiterate Yellowstone's appropriateness for a pilot violence prevention program. Among the entire Yellowstone population, 34.5% live below the poverty level, 50.3% experience food insecurity, and 56.1% of households are single-parent, which are prominent risk factors for community-level violence (Houston Department of Health, 2020). In addition, indicators of community health/well-being are lacking in Greater OST/South Union where 31.1% of the adult population does not have health insurance, 45.2% has high blood pressure, 16.2% has poor mental health, and 45.9% do not get sufficient sleep (Houston Department of Health, 2021).

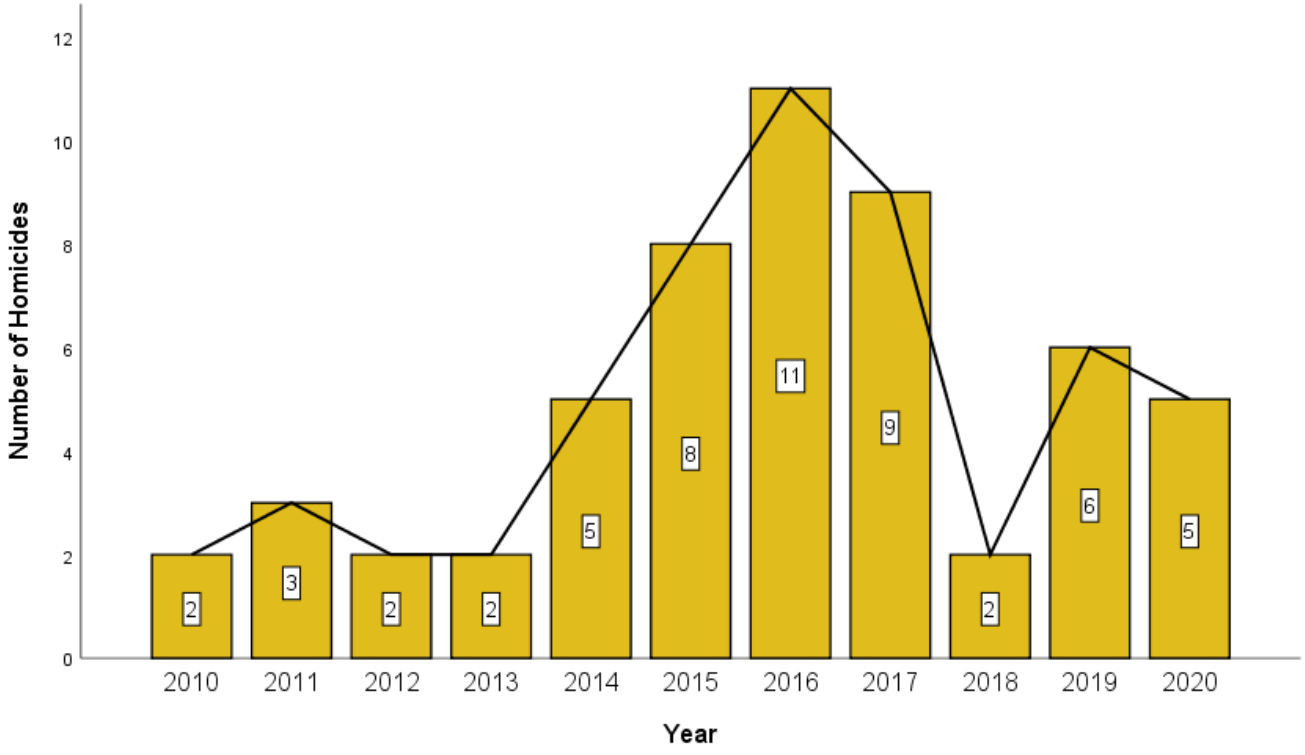
Sharpstown

Sharpstown (zip code 77036) has been historically considered one of the most dangerous neighborhoods in Houston. Sharpstown has a population of 79,481 residents making it one of the most densely populated zip codes in the large city of Houston (Houston Department of Health,

2020). The area is packed with more than 20,000 apartment units across a small geographic area. Close to 30% of the population is age 15-34, making it a prime location for higher levels of offending behavior (Houston Department of Health, 2020). Sharpstown has a uniquely high percentage of Hispanic/Latino residents who make up 63.9% of the community population and a diverse cultural terrain/heritage with the Chinatown and the Mahatma Gandhi Districts located within its borders. Among the population, 32.1% of families overall and 27.9% of children live below the poverty level (Houston Department of Health, 2020). Additionally, only 12.6% of the population 25+ has a Bachelor's degree or higher (Houston Department of Health, 2020). Perpetual high crime levels across time may be associated with these factors as they elevate strain among residents and deteriorate quality of life and the ability to control crime.

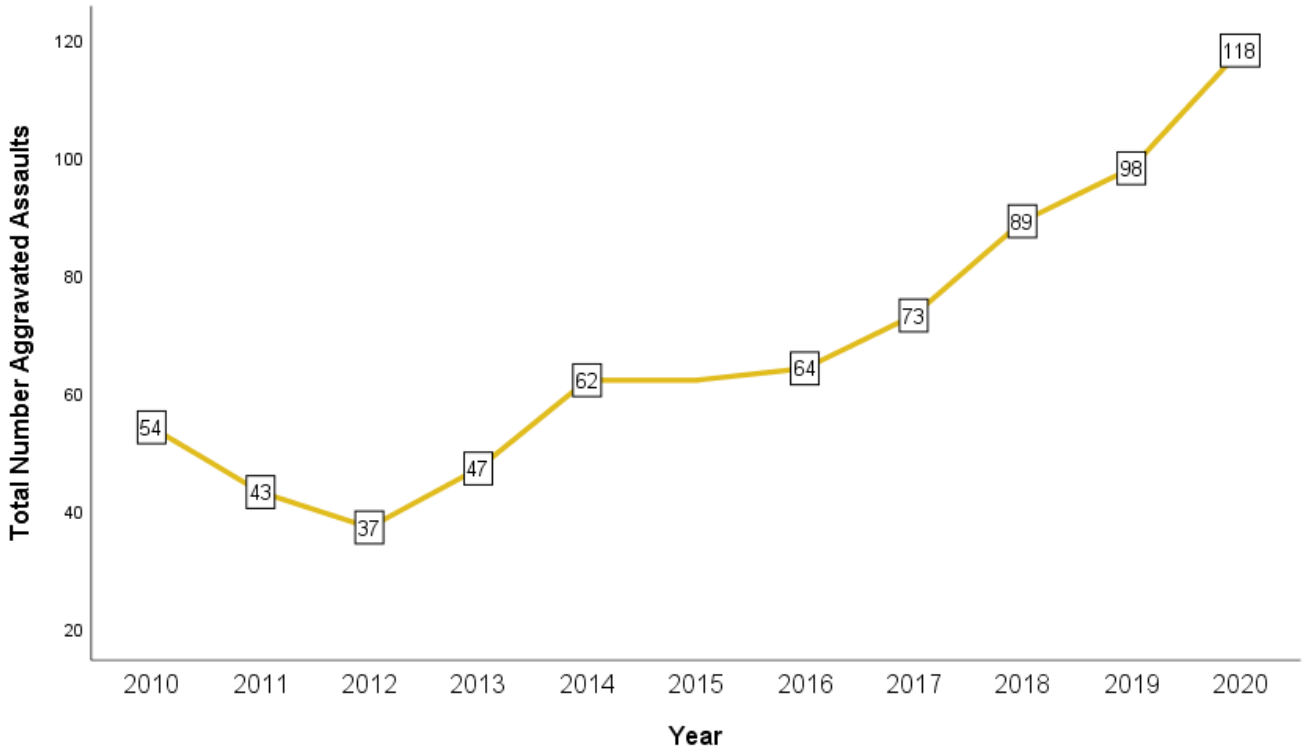
As shown in *Figure 10*, Sharpstown experienced 55 homicides between 2010 and 2020 with an increase from 2 to 5 homicides over time or a 150% rise. Despite COVID-19 and increased social distancing requirements/concerns, Sharpstown had a higher number of

Figure 10: Sharpstown Total Homicides 2010-2020



homicides than 95% of communities in Houston. Murders increased between 2018 and 2019 by 150% and this trend arguably may have continued without the Coronavirus (or other factors not yet identified). Likewise, *Figure 11* shows that aggravated assaults in Sharpstown steadily increased from 54 to 118 or 118.5% between 2010 and 2020.

Figure 11: Sharpstown Total Aggravated Assaults 2010-2020



Other "Good Fit" Neighborhoods for Violence Prevention

Table 1 earlier in the report shows that Cypress Station (zip code 77090) on the northside of Houston has a higher number of aggregate homicides across time than the other communities recommended for the pilot violence prevention program implementation consideration. However, after performing landscape analysis and speaking with prominent anti-violence community leaders (see below), the Cypress Station neighborhood was cut from consideration and replaced with the Greater OST/South Union community. Although Cypress Station has an alarmingly high number of collective homicides across time, it has an insufficient number of

relevant and proximate assets/resources to support the implementation of a pilot program. Like Cypress Station, Greater Greenspoint (zip code 77060) was also excluded from consideration due to a lack of access to services/assets that can support a successful pilot program.

Dr. Chico Tillmon interviewed several Houston residents and prominent Houston violence prevention community leaders who have extensive knowledge of the challenges facing violence prone Houston communities to grow knowledge on violence trends and needs across the larger city landscape. Both community leaders and residents indicated that the Greater Third Ward area (zip code 77004) of Houston has been especially affected by disproportionate levels of violence over time. The Third Ward was excluded from consideration because it has a lower aggregated count of both total homicides and aggravated assaults over time when compared to other communities. The Greater OST/South Union neighborhood has a problematically high number of both homicides and aggravated assaults – thus making it a viable alternative for Cypress Station – and is approximately 1.5 miles away from the Third Ward to the south. Due to the proximity of Greater OST/South Union and the Third Ward, it is highly likely that both share similar characteristics and violence patterns and experience violence spillover effects. With this in mind, implementing the pilot in the Greater OST/South Union community – where data demonstrates disproportionately higher levels of violent crime than other communities – may have positive violence reduction effects on the Third Ward and other proximate communities. Post-pilot program, a similar, yet tailored violence prevention program or programs can be more quickly and easily employed in other community areas of interest to Harris County Precinct 1. Additional good fit neighborhoods for violence prevention programming include Acres Homes (zip code 77088). Harris County may also want to consider the Greater Third Ward for pilot program consideration.

Conclusion

As shown in *Table 3,* instead of implementing violence prevention programs in areas with *both* disproportionately high homicides and aggravated assaults, Harris County may want to situate programs in neighborhoods with a high prevalence of one particular type of crime. For example, Acres Homes (zip code 77088) falls under Sunnyside and Sharpstown with the third highest count of aggravated assaults between 2010-2020. Direct and indirect exposure to violent crime within these areas operate within particular cultural contexts concurrently with structural inequities to reduce residents' ability to achieve optimal health, financial security, and overall safety, which collectively increase the likelihood of violence. Implementation of proven and effective violence prevention programs can help residents subdue the violence that serves to replicate community-wide trauma.

Highest Homicide Neighborhoods 2010-2020	Homicide Total 2010-2020	Highest Aggravated Assault Neighborhoods 2010-2020	AA Total 2010-2020
Sunnyside	***62***	***Sunnyside***	***859***
Cypress Station	61	***Sharpstown***	***747***
Sharpstown	***60***	Acres Homes	702
Greater OST/South Union	***52***	***Greater OST/South Union***	***638***
Greater Grenspoint	51	Cypress Station	573
Acres Homes	47	Eastex/Jensen	573
Greater Third Ward	41	Greater Greenspoint	523
Addicks Park Ten	41	Greater Third Ward	510
Alief	38	Addicks Park Ten	372
Eastex/Jensen	31	Alief	347

Table 3: *Houston communities with the highest numbers of homicides and aggravated assaults.*

`

Landscape Analysis Report: A Focus on Three Proximate Communities

Introduction

This report summarizes the results of extensive landscape analyses performed for three Houston, Texas communities within Harris County Precinct 1 that experience disproportionately high levels of violence (i.e., homicide/gun violence and aggravated assault) when compared to other precinct neighborhoods: 1) *Sunnyside* (includes Sunnyside zip code 77051 and neighboring South Park zip code 77033) on the south side; 2) *Sharpstown* on the southwest side; and 3) *Greater OST/South Union* also on the south side near the Third Ward. A data-informed approach was used to select these communities for potential pilot violence prevention program (PPVP) implementation. The PPVP team analyzed the total counts of homicides and aggravated assaults between 2010 and 2020 across Precinct 1, as well as the quantity and proximity of violence reduction assets to determine which neighborhoods were best-suited for the PPVP or future program implementation post-pilot.

Method

Landscape analysis, also referred to as “asset mapping,” is an essential step in building the foundation for a successful violence prevention program. Asset mapping identifies resources within and proximate to communities with high levels of violence that can improve quality of life and health for residents. Within healthy communities, young men and women are better able to actualize positive alternatives to violence and/or violence exposure, and serve as activists to change community norms that facilitate/perpetuate violence. Asset mapping locates resources and structures close to violence-prone communities that can support violence prevention efforts. Neighborhoods with high rates of violence tend to experience debilitating resource deprivation or

isolation from helpful services that can improve happiness, health, and safety, which limits residents' capacity to avoid, heal from, and prevent/control violence at the community-level.

Landscape analysis was conducted across three Houston communities to identify resources that can address the range of complex, overlapping societal, community, relationship, and individual level(s) factors (i.e., Social-Ecological Model) that put people at risk of violence. Six categories of assets/resources embedded in the public health violence prevention approach were identified and quantified for each community: 1) Healthcare; 2) Education; 3) Economic Stability; 4) Housing and Basic Amenities; 5) Community/Social Cohesion; and 6) Other Social Support. Numbers 1 through 5 are featured in this report. Landscape analysis for the neighborhoods detailed was conducted using Internet searches, online resource mapping tools (Google Maps), and through Houston government social services and nonprofit organizations that provide important quality of life enhancement services to communities and their residents. Assets were searched for using nearby community zip codes, and mapping technology was employed to locate resources within 10 miles of the three selected neighborhoods. The assets included in the analyses are extensive but not exhaustive and can be added to and extended as the PVPP moves forward. The assets included in the landscape analysis are focused on populations/individuals with low income socioeconomic status (SES) with all resources offering free, low-cost/sliding scale/subsidized, and/or Medicaid services. Sunnyside shares a north border with Greater OST/South Union. Additionally, Sharpstown is approximately 7.5 miles away from the other two communities with each having access to similar assets within their individual geographies and the larger Houston cityscape.

Landscape Analysis: Sunnyside, Greater OST/South Union, and Sharpstown

Across all three communities, there is a dearth of resources within each area's geographic boundaries and most residents have to travel 1.5- to 10-miles outside their neighborhoods to obtain services. While travel times to access these services does not appear necessarily troublesome or extensive, ease of access depends on whether residents travel by foot, car, or public transportation. *Figures 12-14* show several of the essential violence prevention assets mapped across the three communities.

Figure 12: ***Sunnyside/South Park*** *economic, healthcare, education, health, and housing/amenities assets within 10-miles of neighborhood.*

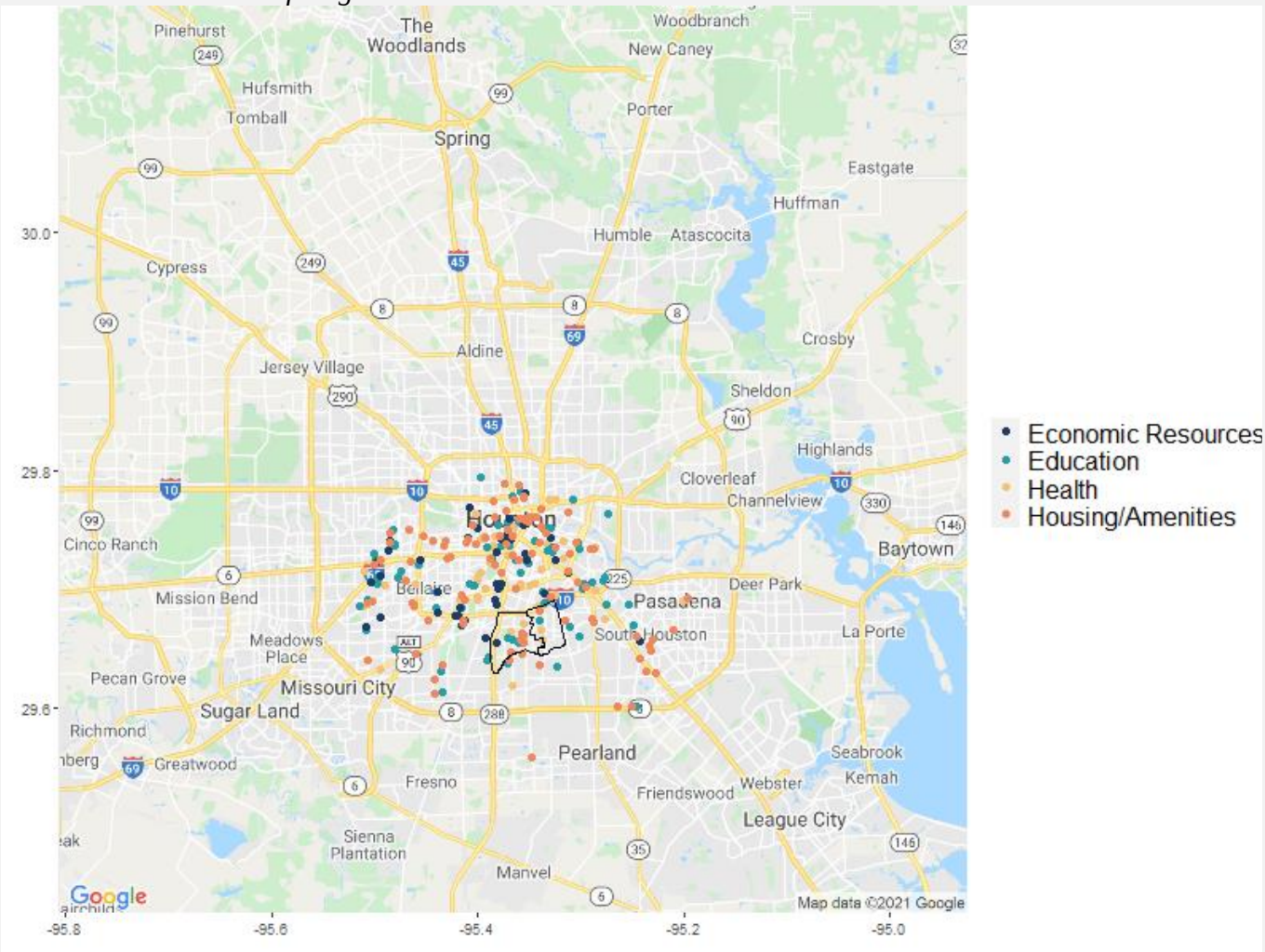
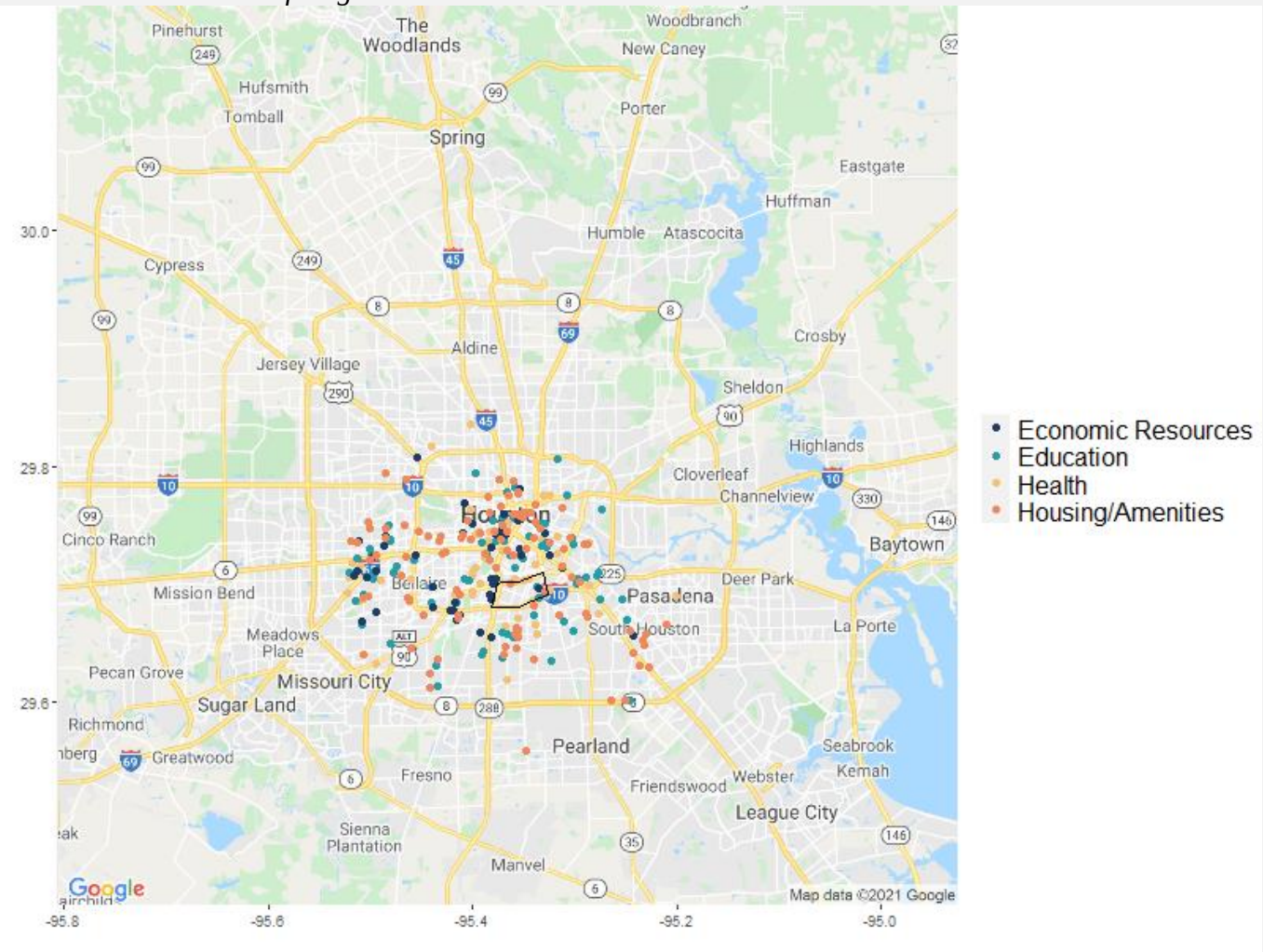


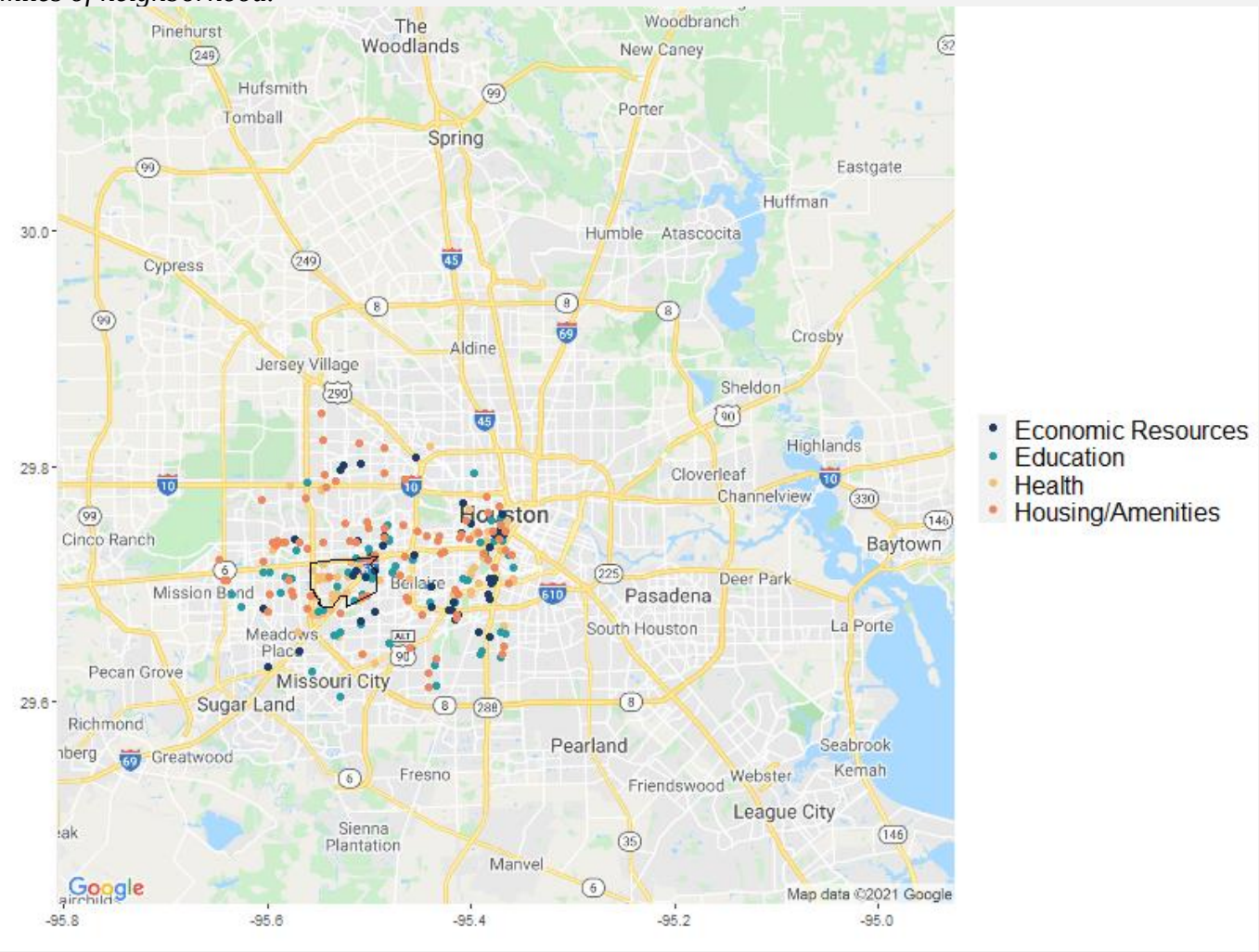
Figure 13: ***Greater OST/South Union*** *economic, healthcare, education, health, and housing/amenities assets within 10-miles of neighborhood.*



Healthcare Assets

Neighborhood residents with adequate or higher access to healthcare are better able to achieve and maintain well-being, take care of their families, envision and take advantage of employment and educational opportunities, and address and recover from the physical and emotional trauma of violence. *Figure 15* displays the healthcare assets/resources within 10 miles of the three selected community areas. In the Sunnyside neighborhood, residents would typically need to travel north 2-6-miles toward the Third Ward and Downtown Houston to obtain

Figure 14: ***Sharpstown*** *economic, healthcare, education, health, and housing/amenities assets within 10-miles of neighborhood.*



healthcare resources. Sharpstown has greater access to healthcare assets within its community boundaries; however, residents would need to travel northeast toward West Oaks as well as west assets than Sunnyside and Sharpstown and is in closer proximity to these services (i.e., 1-4 miles). This community is also situated approximately 1.5-miles from the Third Ward to the south and 3.5-miles from Downtown Houston where a higher concentration of assets exists and northwest toward the Third Ward and Downtown Houston to obtain more prevalently available services. Greater OST/South Union has access to a larger abundance of healthcare services.

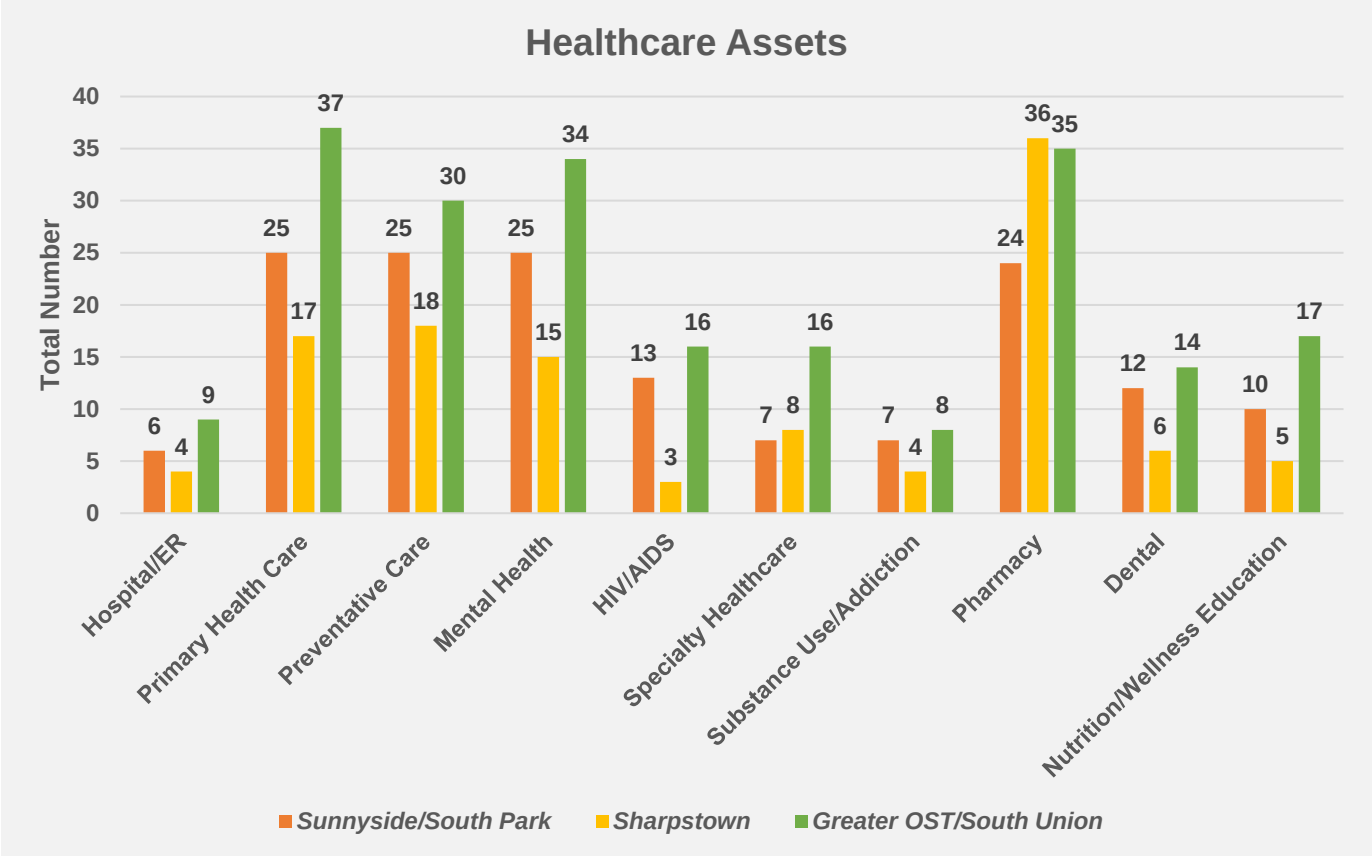


Figure 15: *Total number of varying healthcare assets in each of the 3 recommended communities.*

High levels of persisting violence in each community requires prompt access to trauma 1 hospitals/emergency rooms. Sunnyside is approximately 4-5 miles away from 6 emergency rooms located north of the community, while Greater OST/South Union has access to 9 hospitals with most located directly northwest approximately 1.5-2.5 miles away. Sharpstown has 2 trauma 1 hospitals within the community itself, which is more beneficial for violence prevention purposes when compared to Sunnyside and Greater OST/South Union; however, pending hospital overflow, residents would need to travel approximately 6 miles northeast to access other trauma 1 facilities closer to the Greater OST/South Union community.

The Sunnyside and Greater OST/South Union neighborhoods have access to a strong number of primary health care, preventative care, mental health, and pharmacy services, with

Greater OST/South Union having closer proximity and a higher number than Sunnyside and Sharpstown. Sharpstown is the only neighborhood among the three that has access to several healthcare assets within its borders, and residents would only need to travel 1.5-3.5-miles away to access additional healthcare services in these categories. These healthcare services are typically collectively provided by state-subsidized healthcare clinics or centers (e.g., Harris Health System) that offer multiple types of services all in centralized locations. For example, clinics or organizations providing primary health care also often provide preventative care, mental health services, pharmacy, and sometimes dental care. A handful of these locations also provide nutrition or wellness education as well as HIV/AIDS health care.

A higher number of HIV/AIDS healthcare services exist near Greater OST/South Union than the other two communities. However, these services may often become overwhelmed due to the high prevalence of HIV/AIDS in Houston (the highest rate in the state), which disproportionately affects African American (48.5%) and Hispanic (30.0%) people (City of Houston, 2020); demographics important to the 3 majority communities of color we recommend for the potential PPVP whose residents are often isolated from specialized healthcare options.

Gaps in Services

The three recommended neighborhoods featured in this report all have reduced access to low cost, subsidized, or free specialty/internal medicine and substance addiction/recovery services. High numbers of aggravated assaults (and attempted murders) from year to year may require greater access to specialty care services such as general and orthopedic surgeons and radiologists. Violence is a public health concern and residents living in these communities are frequently exposed to violence or victimization that may require more focused and intensive

treatment provided through internal medicine specialists (Margolin, Vickerman, Oliver, & Gordis, 2010; Meyer, Castro-Schilo, & Aguilar-Gaxiola, 2014).

The three communities also have limited access to substance use/addiction resources. These services are located outside each community's physical boundaries and are likely accessed by thousands of residents across the larger Houston area. As a result, residents within our three communities may be less able to obtain addiction treatment during times of great need. Low-income/subsidized dental services are few and far between across the city of Houston. The lack of dental healthcare within each community may be associated with low levels of clientele due to residents not knowing that such services are available, affordable (sometimes free), and/or covered by Medicaid. Across most healthcare and other asset categories, the Greater OST/South Union neighborhood has access to a higher number of nearby services than the Sunnyside and Sharpstown communities. The Sharpstown neighborhood has diminished access to most healthcare asset types and is more isolated from additional resources further northeast toward the Greater OST/South Union and Third Ward communities.

Education Assets

Figure 16 highlights the number of assets within varying education service categories near each of the three recommended neighborhoods. High school, college/university, and community/adult education (e.g., skills enhancement or knowledge building) create opportunities for individuals to obtain gainful employment and build financial health, experience less economic strain, and better provide for their families and children. Education facilitates economic gains allowing for individuals to live more comfortably and avoid engaging in violence or living in unsafe areas where they and/or their families are unable to thrive. Similar to other asset categories, Greater OST/South Union has a higher number of high schools within 10

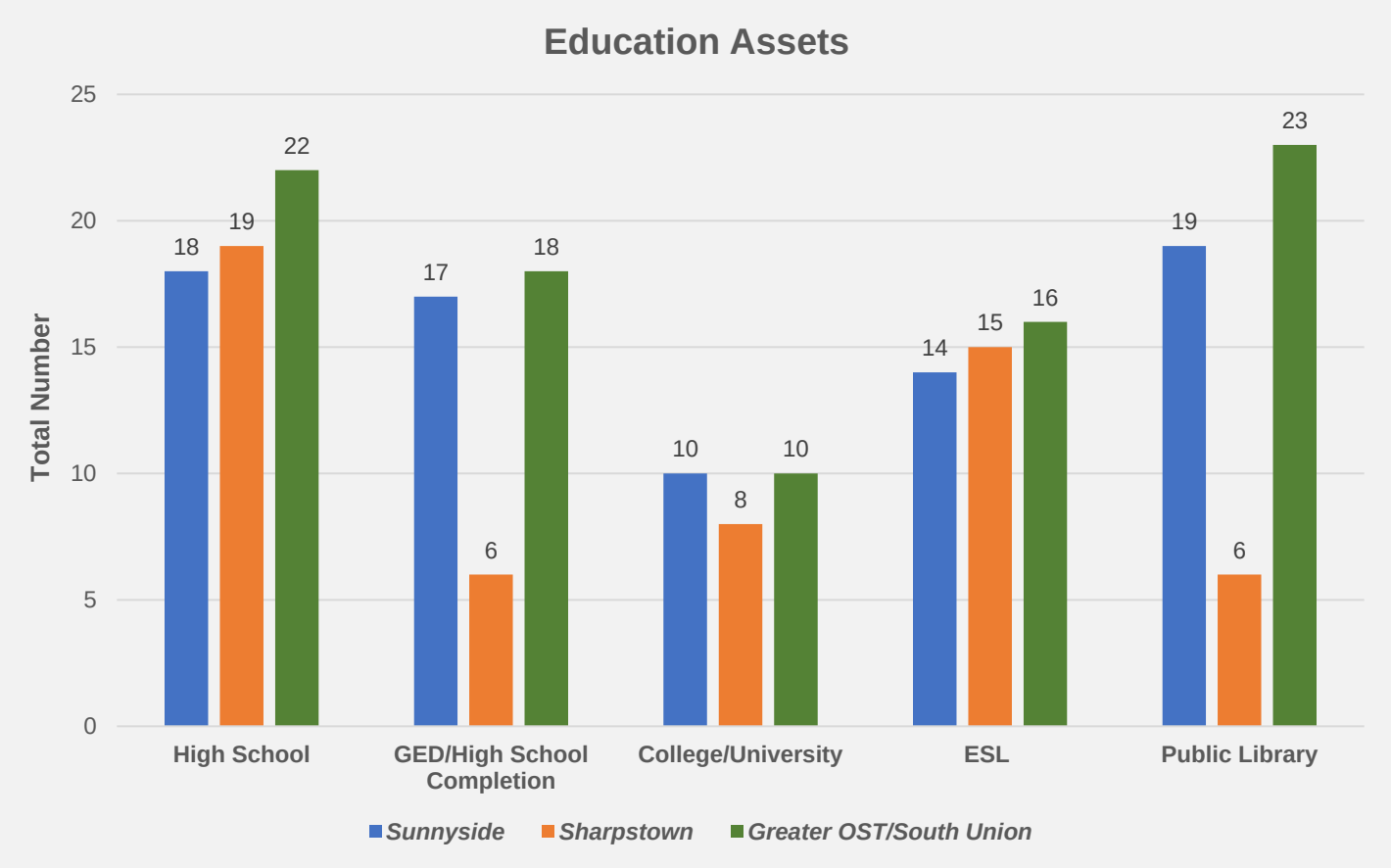


Figure 16: *Total number of varying education assets in each of the 3 recommended communities.*

miles of the community to rely on for children's educational growth than the Sunnyside (a close second) and Sharpstown (third) neighborhoods; however, this community shares its southern border with Sunnyside, and the majority of these high schools are located closer to Sunnyside than Greater OST/South Union. Residents within the latter community often have to travel outside geographic boundaries to access high schools for their children. More research is needed to understand the district placement requirements for each community to determine whether access to education assets may actually be constrained. Similar to the Greater OST/South Union community, Sunnyside residents have overall limited access to education within their community walls, however, several additional high schools are directly outside community borders on the south side less than 1 mile away. Other high schools are located approximately 3-4 miles away.

Several of these high schools are magnet schools with academic focus areas such as engineering or medicine. These schools provide numerous benefits to students allowing for practical application of job skills and college acceptance and placement. However, it is unclear whether teenagers living in the three recommended communities are attending these magnet schools or other charter or public high schools. Each type of high school included in this report is part of the Houston Independent School District and thus free to all attending students. Sharpstown has reduced access to high schools when compared to Greater OST/South Union (a small difference); however, unlike the other two communities, there are several high schools *within* the community boundaries, with others located no further than 1-3 miles away. The higher number of high schools within Sharpstown may help to explain why the community has a lower number of high school completion assets when compared to Sunnyside and Greater OST/South Union.

Sunnyside and Greater OST/South Union have similar access to numerous GED/high school completion assets when compared to Sharpstown. Sunnyside is situated approximately 5-7-miles away from these education resources that are located north of the community toward Greater OST/South Union and the Third Ward area, which may create burdens for residents and returning citizens who do not have a car or cannot afford transportation. Given this, Greater OST/South Union has greater and easier access to GED and high school completion resources. Additionally, a generous number of public libraries exist in close proximity to the Greater OST/South Union and Sunnyside communities. Sharpstown however is isolated from more plentiful libraries near the Greater OST/South Union neighborhood. Sunnyside residents have access to a small number of libraries within 0.5-3-miles away with the majority located further northeast and northwest about 4-7 miles away in closer proximity to the Greater OST/South Union neighborhood. At the same time, many available libraries are tucked within small

neighborhood areas, which may be difficult to find and access among those from outside communities. Sunnyside is located approximately 4-7 miles away from colleges or universities situated further north closer to the Greater OST/South Union community. Finally, all three neighborhoods have similar access to numerous English as a Second Language (ESL) education services; however, given that 45% of the Houston population is comprised of Latinos (U.S. Census Bureau, 2019), these services may be overwhelmed and difficult to access immediately.

Economic Stability Assets

Figure 17 displays the economic stability resources in the three recommended community areas. Economic stability provided by gainful employment opportunities and sufficient financial capital to pay the rent, buy food, purchase gasoline, enjoy fun activities, and care for self and family allow for individuals to enhance and sustain quality of life. Communities experiencing high levels of violence typically have diminished access to economic stability assets and thus face disproportionate challenges living comfortably, avoiding debilitating stress and anxiety, and feeling healthy and happy. The Sunnyside and Greater OST/South Union communities have access to numerous job search training and counseling resources that provide services such as resume writing, interview skills, counseling (e.g., aligning skills with careers), online job searches, filling out applications, and professional dress/presentation during interviews. Many of the assets providing the aforementioned services also offer job placement and unemployment assistance thus providing a convenient, one-stop-shop approach to supporting those struggling with employment concerns. For the Sunnyside neighborhood, the majority of these assets are located further north approximately 3-5 miles away in close proximity to the Greater OST/South Union community. The Sharpstown neighborhood has limited access to economic stability assets when compared to the other two communities; however, this may be

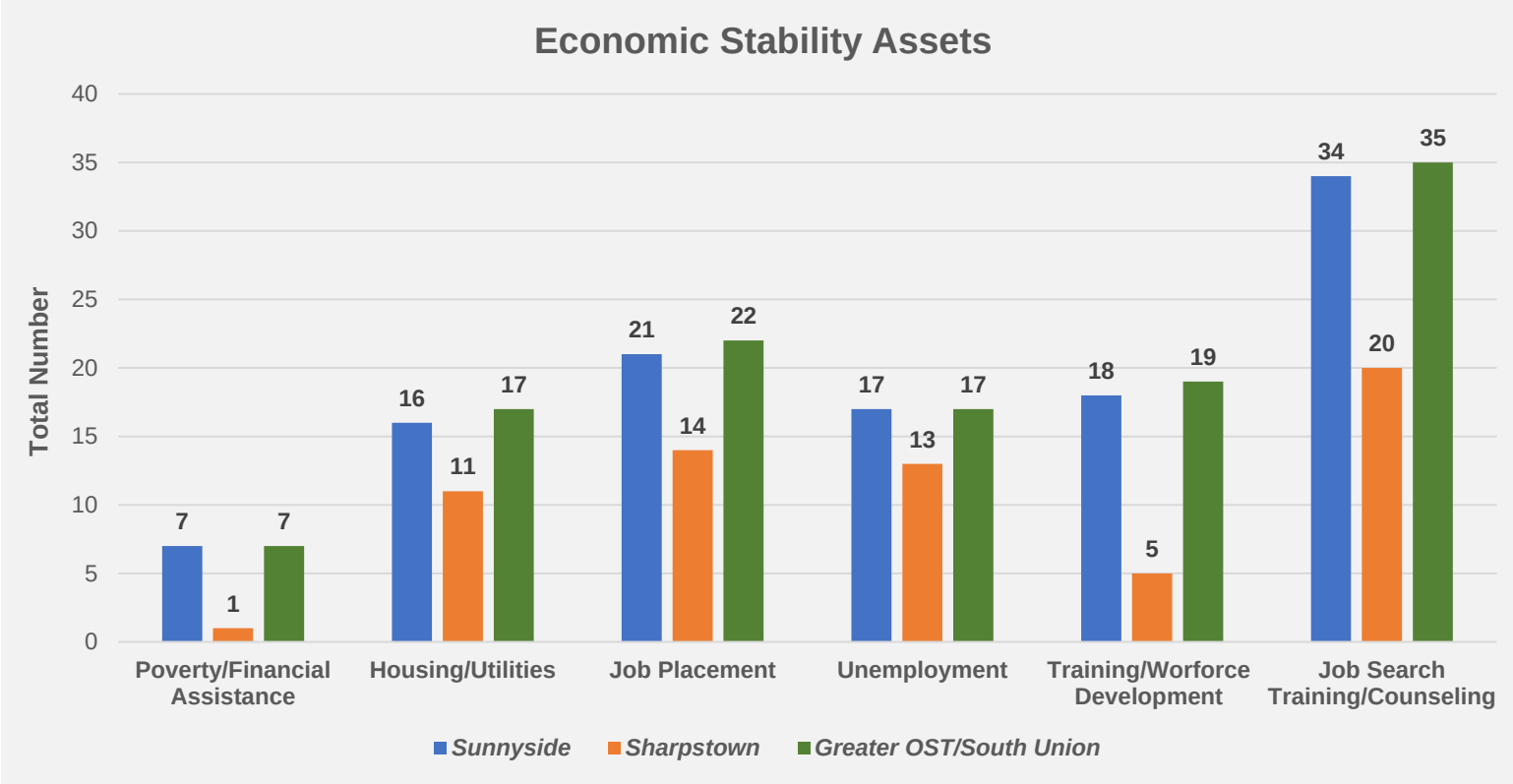


Figure 17: *Total number of economic stability assets in the three recommended community areas.*

because Sharpstown has an approximate 8% unemployment rate compared to Sunnyside's 25% and Greater OST/South Unions' 16% unemployment rates (City of Houston, 2018). Labor force numbers used for these statistics do not account for those not actively looking for employment, a demographic that may be more prevalent within communities with elevated rates of gang activity and violence. If we examine unemployment to mean individuals who are not working in the labor market and receiving income within conventional employment, and those who are not seeking such employment, the rate of "actual" unemployment is likely much higher in these communities. Among these varying resources, Sharpstown has the greatest access to job search/training/counseling services versus other economic stability assets.

Workforce training and development resources help individuals to enhance their current job skills (e.g., productivity, interacting with supervisors and colleagues) and performance to increase promotion opportunities or succeed at work. Sunnyside and Greater OST/South Union are situated within 10 miles of a substantial number of workforce training and development services. Surprisingly however, Sharpstown has a slightly lower number of these assets when compared to the other two communities despite having a larger population overall and a working population more specifically (City of Houston, 2018). In addition, Sunnyside and Greater OST/South Union are near (Greater OST/South Union more so than Sunnyside) numerous services that provide financial assistance to support individuals with low SES and experiencing residential instability, including rent payments and eviction services/housing, emergency shelter, temporary housing, and utilities bills. It is important to note however that the majority of economic stability assets included in this analysis are provided by the state/city governments and thus are likely accessed by thousands of individuals across the city. With this in mind, more numerous economic stability resources may not mean improved access to these assets.

Gaps in Services

A minimal number of services across the three recommended neighborhoods provide assistance to individuals needing help filling out and submitting applications to the state/city government to obtain financial social services such as Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC), Medicaid, and Children's Health Insurance Program (CHIP), as well as accessing other benefits including food and transportation financial assistance, and prescription/medical discounts/vouchers. This collective lack of resources is problematic given the complexity of filling out paperwork and the process to obtain government financial assistance. Additionally, housing resources (e.g., rent payments, eviction assistance, emergency shelter, temporary housing, finding quality/safe/affordable housing) that provide aid to individuals with low SES are typically cash strapped and unable to meet the needs of the high volume of individuals requiring financial assistance for housing crises or challenges. More abundant economic stability resources and better funding for existing economic stability resources may benefit communities experiencing financial and housing hardships.

Housing and Basic Amenities

Figure 18 shows the total number of housing and basic living amenities located within 10 miles of the three PPVP recommended communities. The resources within this asset category are specific to housing and other amenities that provide individuals with food and affordable, quality, and/or emergency housing and shelter. Access to nutritious food, and safe, affordable, and quality housing facilitates healthy living, comfort, and safety. Healthy food access is essential to overall well-being as it reduces obesity and other diseases (e.g., heart disease and diabetes) and provides the sustenance necessary to be active and feel strong enough to take on everyday challenges. Access to affordable, quality housing also disrupts residential instability

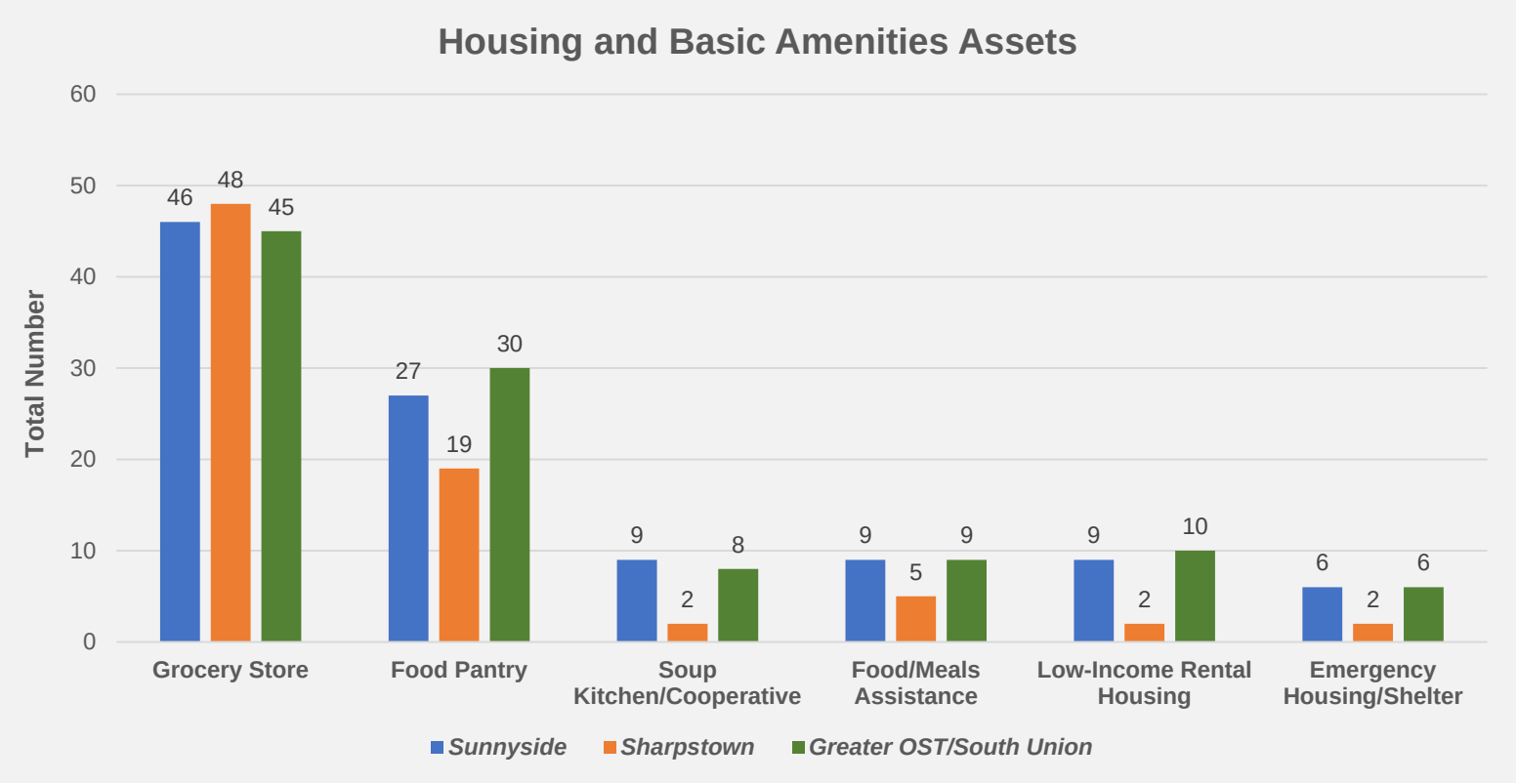


Figure 18: *Total number of housing and basic amenities assets in the three recommended community areas.*

that fractures social cohesion and deteriorates community living conditions, both of which are associated with high rates of violence.

The Sunnyside and Greater OST/South Union neighborhoods are similar in that they have approximately 2-3 grocery stores situated within community walls. The Sunnyside neighborhood has reduced access to full-service grocery stores when compared to the other two communities. Sunnyside has multiple grocery stores spread around the geographic area to the south, west, and east approximately 1-3 miles away; however, there is a larger quantity of grocery stores further north/northwest 4-6 miles away closer to the Greater OST/South Union neighborhood and Third Ward. Similar to the other communities, Sharpstown has a small number of grocery stores within the neighborhood itself (surprising given approximately 80,000 people live in Sharpstown compared to ~40,000 in Sunnyside and ~20,000 in Greater OST/South Union; United States Census Bureau, 2020); yet has substantial access to numerous grocery stores outside community borders approximately 2-3.5 miles away.

Greater OST/South Union has access to a higher number of food pantries than the other two communities. The Sunnyside community has access to a similar number of food pantries, however the majority of these are located greater than 4.5-miles away. Greater OST/South Union is in closer proximity (1-3 miles away) to free food pantries when compared to the other two communities. The majority of these pantries provide free groceries first come, first serve, until product runs out, and Sunnyside residents may struggle to locate and obtain available food due to not being as close to the pantries as other Houstonians facing food insecurity.

Gaps in Services

There is a problematically limited number of soup kitchens/food cooperatives and food/meals assistance assets across all three neighborhoods, with Sunnyside and Greater

OST/South Union having similarly low numbers and Sharpstown having especially sparse counts. Each of the three communities or community areas analyzed in this report has been identified by the United States Department of Agriculture as food deserts (Rice Kinder Institute of Urban Research, 2019) with residents experiencing substantial and debilitating food insecurity. While an ample number of chain, corporate grocery stores are located in the Houston area and a fairly reasonable distance from the three neighborhoods, residents experiencing poverty may be unable to afford store food, making outside nonprofit and government provided food services such as soup kitchens/cooperatives and food and meals financial and provision services absolutely essential to support those who are hungry and at high risk of violence or living in poverty. However, all three communities have an exceptionally small numbers of these services (10 or below) to rely on within the larger Houston community.

Additionally, there is a troublingly minimal number of emergency housing/shelters for individuals experiencing financial distress or crises across the three recommended PVPP neighborhoods. Sunnyside and Greater OST/South Union each has access to 6 emergency housing/shelters and Sharpstown alarmingly only has access to 2. Similarly, the City of Houston recently built numerous quality apartment communities for Houstonians experiencing residential instability and poverty within 10 miles of the three communities. However, competition for these rentals is high across the city thus potentially restricting access to hundreds of individuals in need of such housing accommodations.

Community Enhancement and Social Cohesion Assets

Figure 19 illustrates the total number of varying types of community enhancement and social cohesion assets within and close to the three potential AAVP communities. These assets operate to provide essential social services, volunteer opportunities, or outdoor

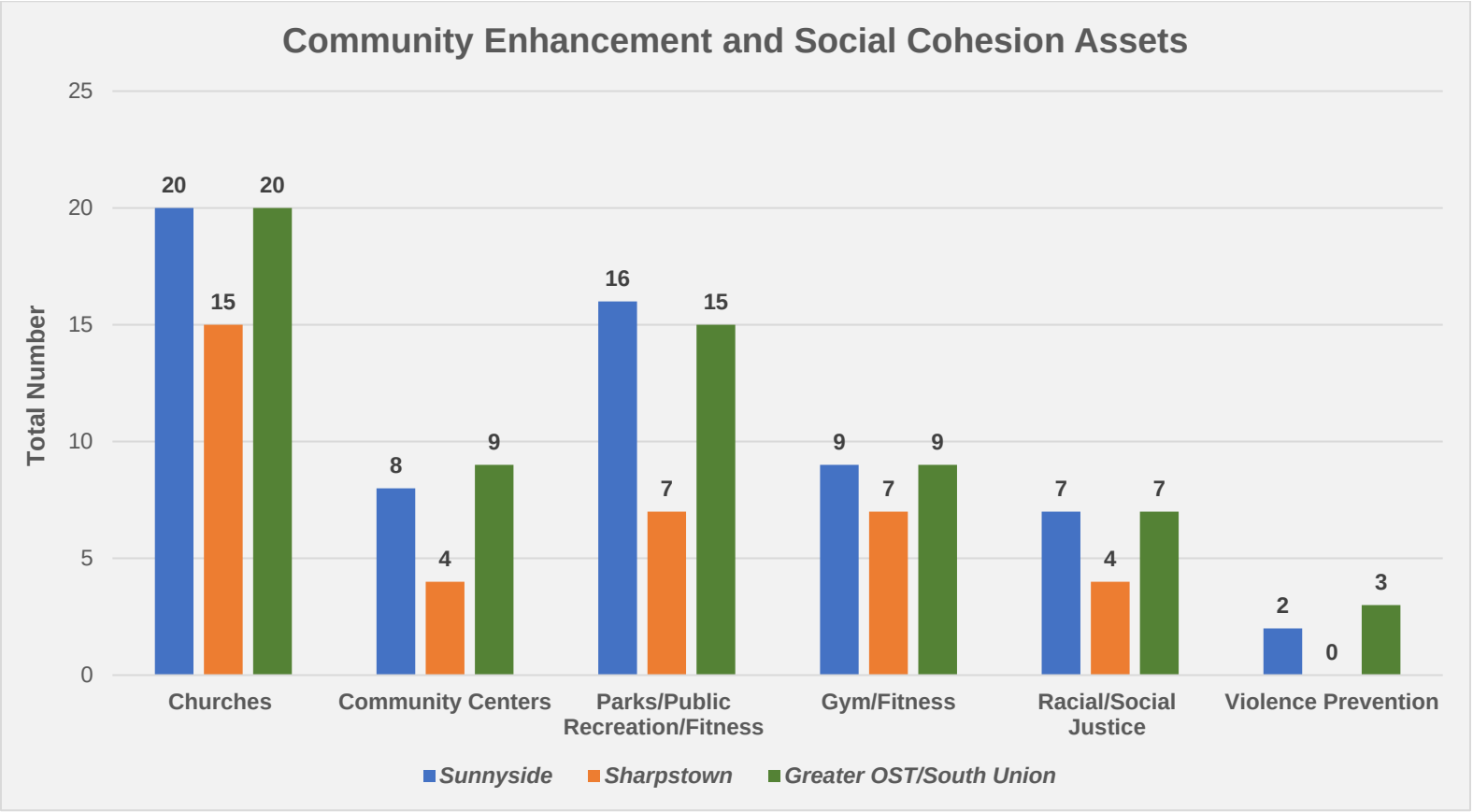


Figure 19: *Total number of varying community enhancement and social cohesion assets in each of the 3 recommended communities.*

recreation/physical fitness activities/programs to families, children, and adults, or advocate for racial/ethnic, immigrant, and/or social justice to enhance quality of life, build social cohesion, and foster and fortify neighborhood health and capacity to resist violence and implement anti-violence stewardship through practice and conversation.

All three communities have similar quantities of churches within 10 miles of their situated locations. Sunnyside and Greater OST/South Union each have access to 20 churches; however, these churches vary in denomination with most being Christian (Baptist, Christian, Catholic, Presbyterian, or Methodist). With this in mind, residents' access to religious services may be substantially reduced depending on the religious denomination to which residents identify. There are also a small number of community centers within or proximate to the three communities with Sunnyside and Greater OST/South Union having similar and the highest numbers of centers when compared to Sharpstown. These community centers provide residents with a place to meet for group and family activities, varying types of classes, dinners and functions, and other purposes intended to elevate community social cohesion and support. Similarly, the City of Houston Parks and Recreation Department has constructed numerous facilities in close proximity to the three recommended communities that are also referred to as community centers, but provide residents access to parks, green space, weights/fitness rooms, and recreation programming and activities. Sunnyside and Greater OST have access to plentiful parks and recreation centers, while Sharpstown has access to only a small handful of locations. These parks and recreation assets also often provide weights and fitness rooms for community members to exercise. Similarly, each of the three neighborhoods has access to a small number of other gyms/fitness centers that are nearby, which provide exercise, weights, and fitness classes for community members throughout the larger Houston area low-cost or on a sliding scale.

Gaps in Services

All three communities have a small quantity of racial/ethnic, immigration, and social justice organizations that advocate for the legal and constitutional rights of people of color and immigrants; equitable access to services that improve quality of life and are essential to the pursuit of happiness; and against institutionalized racism, discrimination, and police/criminal legal system violence. Sunnyside and Greater OST/South Union have higher (and equal) numbers of these services than Sharpstown. Social and institutional support for the establishment of such organizations would serve to foster and grow neighborhood unity, facilitate access to support networks and services, and address/correct injustice and mistreatment from institutions that have a tremendous amount of power and influence. Finally, violence prevention programming within the three recommended communities as well as the larger Houston area is sparse providing an excellent opportunity for the current PVPP to develop more substantial and effective violence prevention infrastructure in Houston.

Conclusion

Post PPVP implementation and conclusion, the program can be more easily employed/replicated in other communities. Based on our analysis, we recommend Harris County select the Greater OST/South Union neighborhood with Sunnyside as a second option. Greater OST/South Union has greater access to assets that can enhance community-level well-being thus fostering violence reduction than Sunnyside and Sharpstown. However, any of the three communities are viable options for PVPP consideration and implementation.

Qualitative Interviews: Examining Community Challenges and Violence with Houston, TX Anti-Violence Leaders on the Ground

To forward efforts toward identifying and deciding upon Houston, Texas Precinct 1 neighborhoods ideally suited for violence prevention programming, Dr. Chico Tillmon conducted qualitative interviews with six (6) prominent anti-violence community leaders/activists and fifteen (15) residents who have extensive history in Houston and knowledge of the challenges facing communities with high violence levels. Community leaders interviewed include: *Deric Muhammad* – social/racial justice activist, organizer, and author; *Dr. Robert Muhammad* – student minister for the Nation of Islam and racial/social justice activist; *Charles Rotramel* – Chief Executive Officer of nonprofit, "reVision," that provides mentorship and other social support to juvenile justice connected youth; and *Reginald Gordon* – returning citizen who spent 17 years in prison and is now a racial/social justice activist offering mentorship and services to communities of color and youth through his "Operation Outreach OG1" program. Dr. Tillmon toured Houston with these important figures to garner an enhanced understanding of structural challenges facing Precinct 1's marginalized communities and associated high violence trends and concerns.

Dr. Tillmon interviewed community leaders and residents using a semi-structured, 8-question interview guide and took detailed notes to prompt relevant follow-up questions. Interview data analysis revealed parallel themes and responses and are summarized below. Questions were geared toward assessing participants' perspectives of which communities have troublingly pronounced levels of violence and the challenges they face. Community leaders and residents similarly identified Sunnyside, Southwest Houston, the Third and Fifth Wards, Acres Homes, and Greater OST/South Union (referred to as "Yellowstone") as having recurrently high rates of violence across time. Dr. Tillmon and his violence prevention research team performed

analyses of Houston violent crime data and similarly identified the Sunnyside, Sharpstown (i.e., Southwest Houston), and Greater OST/South Union (or Yellowstone) communities as having some of the highest levels of violent crime in the city. Such feedback helped to triangulate Dr. Tillmon's recommendations for these communities to be principally considered for the Harris County's pilot violence prevention program.

Dr. Tillmon also asked participants about perceived factors contributing to increased violence in Houston communities. Participants detailed that neighborhood characteristics such as extensive and increasing gentrification (and associated high taxes), displacement, poverty, lack of access to resources and wealth, limited economic opportunities, food deserts, perpetuating gang culture, and easy access to firearms contributed to increased violence challenges. They indicated that crime has become normalized in high violence communities across time in part due to dedicated violence prevention organizations/activists working tirelessly with no access to resources, which has limited horizontal growth and capacity to perform work that will cause "real," significant change. Most violence prevention staff are on the ground "doing the work" in Houston communities without "being seen" by residents or becoming integrated in community life, which limits the potential for "real change."

Interview participants also listed specific programs or organizations in the Houston area devoted to building peaceful, healthy communities that can be integrated into the Harris County pilot violence prevention program's asst/resource network to provide support to anti-violence efforts and clients identified as high risk. Creating working partnerships with these anti-violence programs and leaders has the potential to cultivate and strengthen the impact of the pilot program, as well as violence reduction and quality of life enrichment initiatives/programs across Houston, enabling marked reductions in violence and healthier communities. Some of the anti-

violence organizations/programs mentioned by interview participants include: *A.C.T.I.O.N CDC* – (community enhancement); *OG1 Operation Outreach* (youth violence prevention through education [run by Reginald Gordon detailed earlier]); the *Harris County Youth Collective* (connects organizations, individuals, and advocates to create solutions for at-risk youth in both the juvenile justice and child protective systems [i.e., dual status] to achieve their full potential); the *Center for Urban Transportation* (creates opportunities/programs for Fifth Ward families to overcome the detrimental effects of racism, poverty, and other inequities to elevate personal and community success); *United in Peace* (designs and implements security and safety models tailored to individual neighborhoods to foster equitable and resilient economic development); and *Shape Community Center* (offers programs and activities that emphasize/normalize unity, self-determination, collective work and responsibility, cooperative economics, etc. to enhance individuals' quality of life). Participants similarly offered the names of several individuals leading violence prevention efforts throughout Houston communities, including *Dieter Cantu* (Youth Justice Director at Harris County Youth Collective), *Oquinne Nichols* (former member of Bloods gang and current pastor), and *Adrian Garcia* (Commissioner of Harris County Precinct 2). Dr. Tillmon also had the honor of speaking with *Calandrian Kemp* who is an anti-gun activist working individually and with varying Houston organizations to lobby for stricter firearm laws.

Finally, participants described several recommendations to address the problem of violence in marginalized communities. Participants described violence prevention programs/organizations consistently having inadequate funding to support anti-violence efforts; the problems of which are exacerbated by a lack of effective organizing and creating "Band-Aid," solutions incapable of meaningfully addressing an entrenched, perpetuating violence epidemic. Recommendations for these challenges included increasing government funding for

violence prevention programming that is substantial enough to support organizations already on the ground, as well as create new organizations that are highly organized and focused on and capable of consistent follow-up and high-impact violence reduction and community change. In so doing, community members will be better able to connect with and invested in working with organizations to *truly* reduce violence in impacted neighborhoods. Given that the majority of violence prevention efforts/programs are staffed by volunteers, participants suggested that violence reduction effects would be better realized through funding staff and establishing sound, strong infrastructure to powerfully affect change. Participants also proposed that violence prevention work should place a strong emphasis on creating economic opportunities for high-risk individuals living in communities with alarmingly high violence rates. Similarly, such work should stress nurturing and loving those exposed to violence, keeping kids in school, rebuilding the positive concept/strength of families, and developing community cohesion and solidarity.

Potential Funding Streams for Violence Prevention

Table 4 on the next page displays the different streams of available or soon to be available funding that can support violence prevention programming in Harris County Precinct 1. These funding streams highlight the multiple opportunities accessible to build and sustain a successful violence prevention pilot and future violence prevention programs in Harris County high-violence neighborhoods. Well-funded public health-focused violence prevention efforts have the potential to grow and enhance community residents' health, happiness, success, and strength, as well as substantially reduce violent crime and improve resident safety. Anti-violence organizations and activists are working hard across the country to ensure the federal and state governments allocate funding for Black and Brown communities struggling with high levels of perpetuating violence in their communities. *The total amount of available funding across federal, private, and other sources is $10.2 billion.*

FEDERAL FUNDING STREAMS		
Title of Funding Source	**Funding Amount ($)**	**Notes**
Infrastructure Bill	$5 billion	Distributed over 8 years for community violence prevention intervention – potential vote Aug 2021
Appropriations Bill for 2022 FY	$200 million	Proposed by White House – potential vote Oct 2021
Executive Actions from White House	Varies	Prioritized 26 existing federal grant programs for violence prevention.
American Rescue Plan (ARP)	$350 billion	Can be used to address rise in gun violence during and following COVID-19. Funding can be used through 2024 and goes directly to cities, counties, and states. Provides potential funding streams from city, county, and state governments.
PRIVATE/PHILANTHROPIC FUNDING STREAMS		
Robert L. McCormick Foundation	Varies	Crisis Response and Youth Connections grants to address gun violence in Chicago communities.
Robert Wood Johnson Foundation	Varies	Social Determinants of Health grants that provide funding to support enhancing safety in communities to foster community well-being.
MacArthur Foundation	Varies	Grants for programs that create programs to address social problems in Chicago communities.
The Joyce Foundation	Varies	Grants for programs that enhance racial equity.
Local foundations	Varies	Hundreds of local organizations invested in community health and well-being across the country provide funding opportunities.
Individual giving/philanthropic	Unlimited	Community education efforts, the continued success of violence prevention programs, and increased notoriety will generate donations and philanthropic giving.

Table 4: *Varying funding streams available to support Harris County's violence prevention initiatives currently and in the future.*

References

Alba R., & Nee V. (1997). Rethinking assimilation theory for a new era of immigration. *International Migration Review, 31*(4), 826–874.

Alim, T. N., Charney, D. S., & Mellman, T. A. (2006). An overview of posttraumatic stress disorder in African Americans. *Journal of Clinical Psychology, 62*(7), 801-813.

Allard, S. W., & Smith, S. R. (2014). Unforeseen consequences: Medicaid and the funding of nonprofit service organizations. *Journal of Health Politics, Policy & Law, 39*(6), 1135–1172.

Alleyne, E., & Wood, J. L. (2014). Gang involvement: Social and environmental factors. *Crime & Delinquency, 60*(4), 547–568.

American Public Health Association. (2018, November 13). Violence is a public health issue: Public health is essential to understanding and treating violence in the U.S. Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/28/violence-is-a-public-health-issue.

Anderson, E. R., & Mayes, L. C. (2010) Race/ethnicity and internalizing disorders in youth: A review. *Clinical Psychology Review, 30*, 338–348.

Austria, R., & Peterson, J. (2017). Credible messenger mentoring for justice-involved youth. *The Pinkerton Papers.* http://www.thepinkertonfoundation.org/wpcontent/uploads/2017/02/Pinkerton-Paperscredible-messenger-monitoring.pdf

Bazarian, J. J., McClung, J., Shah, M. N., Cheng, Y. T., Flesher, W., & Kraus, J. (2005). Mild traumatic brain injury in the United States, 1998–2000. *Brain Injuries,* 19, 85–91.

Beardslee, J., Mulvey, E., Schubert, C., Allison, P., Infante, A., & Pardini, D. (2018). Gun- and non-gun-related violence exposure and risk for subsequent gun carrying among male juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry, 57*(4), 274–279.

Bingenheimer, J. B., Brennan, R. T., & Earls, F. J. (2005). Firearm violence exposure and serious violent behavior. *Science, 308*(5726), 1323-1326.

Braakman, N. (2013). How do individuals deal with victimization and victimization risk? Longitudinal evidence from Mexico. *Journal of Economic Behavior and Organization, 84*, 335–344.

Braga, A. A., Kennedy, D. M., Piehl, A. M., & Waring, E. J. (2001). Reducing gun violence: The Boston Gun Project's Operation Ceasefire (#NCJ 188741). Department of Justice, National Institute of Justice.

Braga, A. A., Papachristos, A. V., & Hureau, D. M. (2014). The effects of hot spots policing on crime: An updated systematic review and meta-analysis. *Justice Quarterly, 31*, 633–663.

Braga, A. A., Weisburd, D., & Tuchcan, B. (2018). Focused deterrence strategies and crime control: An updated systematic review and meta-analysis of the empirical evidence. *Criminology & Public Policy,* 17(1), 205-250.

Brown, J. R., Hill, H. M., & Lambert, S. F. (2005). Traumatic stress symptoms in women exposed to community and partner violence. *Journal of Interpersonal Violence, 20,* 1478–1494.

Buck, G. (2016). 'I wanted to feel the way they did': Mimesis as a situational dynamic of peer mentoring by ex-offenders. *Deviant Behavior, 38*(9), 1–15.

Buckner, J. C., Beardslee, W. R., & Bassuk, E. L. (2004). Exposure to violence and low-income children's mental health: Direct, moderated, and mediated relations. *American Journal of Orthopsychiatry, 74*, 413–423.

Buka, S. L., Stichick, T. L., Birdthistle, I., & Earls, F. (2001). Youth exposure to violence: Prevalence, risks, and consequences. *American Journal of Orthopsychiatry, 71*, 298-310.

Burgers, D. E., & Drabick, D. A. (2016). Community violence exposure and generalized anxiety symptoms: Does executive functioning serve a moderating role among low income, urban youth? *Journal of Abnormal Child Psychology, 44*(8), 1543-1557.

Butcher, F., Galanek, J. D., Kretschmar, J. M., & Flannery, D. J. (2015). The impact of neighborhood disorganization on neighborhood exposure to violence, trauma symptoms, and social relationships among at-risk youth. *Social Science and Medicine, 146*, 300-306.

Butts, J. A., & Delgado, S. A. (2017). Repairing trust: Young men in neighborhoods with Cure Violence programs report growing confidence in police. John Jay Research and Evaluation Center, Research Brief.

Butts, J. A., Gouvis Roman, C., Bostwick, L., & Porter, J. (2015). Cure Violence: A public health model to reduce gun violence. *Annual Review of Public Health, 36*, 39–53.

Centers for Disease Control and Prevention (CDC). (2017). Leading causes of death - males - Non-Hispanic black - United States, 2017. Retrieved from https://www.cdc.gov/healthequity/lcod/men/2017/nonhispanic-black/index.htm.

Centers for Disease Control and Prevention (CDC). (2019). Assault or homicide. Retrieved from https://www.cdc.gov/nchs/fastats/homicide.htm.

Centers for Disease Control and Prevention (CDC). (2020). Violence prevention. Retrieved from https://www.cdc.gov/violenceprevention/publichealthissue/timeline.html.

Cerdá, M., Tracy, M., & Keyes, K. M. (2017). Reducing urban violence: A contrast of public health and criminal justice approaches. *Epidemiology, 29*(1), 142–150.

Chalfin, A. (2015). Economic costs of crime. *The Encyclopedia of Crime and Justice,* Wiley.

City of Houston. (2020). HIV in the Houston area. Retrieved from https://www.houstontx.gov/health/HIV-STD/Documents/Epi-Supplement-Final-20200312.pdf.

City of Milwaukee. (2020). 414Life: Milwaukee Blueprint for Peace. Retrieved from https://city.milwaukee.gov/414Life/Blueprint.

City of New Orleans. (2016). NOLAForLife 2016 progress report. Retrieved from https://1vp6u534z5kr2qmr0w11t7ub-wpengine.netdna-ssl.com/wp-content/uploads/2019/09/NOLAFORLIFE_ProgressReport_2016_LONG_070816-web-1.pdf.

Clark, P. (2010, March 28). Preventing future crime with cognitive behavioral therapy. National Institute of Justice. Retrieved from https://nij.ojp.gov/topics/articles/preventing-future-crime-cognitive-behavioral-therapy#referrer2.

Clark, C., Ryan, L., Kawachi, I., Canner, M. J., Berkman, L., & Wright, R. J. (2008). Witnessing community violence in residential neighborhoods: A mental health hazard for urban women. *Journal of Urban Health, 85*, 22–38.

Comstock, G. W. (1982). Epidemiology of tuberculosis. *American Review of Respiratory Diseases, 125*(3), 8-15.

Credible Messenger. (2017). In *Cure Violence Glossary*. https://johnjayrec.nyc/2015/04/17/cvglossary/

Credible Messengers Justice Center. (n.d.). *The credible messenger approach.* https://cmjcenter.org/approach/

Cure Violence Global. (2019). *The 5 required components of cure violence*. https://cvg.org/wp-content/uploads/2019/12/2019.12.12-Cure-Violence-Criteria.pdf

Cure Violence Global. (2020). Community based public safety solutions. Retrieved from https://cvg.org/.

Curry, A., Latkin, C., & Davey-Rothwell, M. (2008). Pathways to depression: The impact of neighborhood violent crime on inner-city residents in Baltimore, Maryland, USA. *Social Science and Medicine, 67*, 23–30.

Delaney-Black, V., Covington, C., Ondersma, S. J., Nordstrom-Klee, B., Templin, T., Ager, J., Janisse, J., & Sokol, R. J. (2002). Violence exposure, trauma, and IQ and/or reading deficits among urban children. *Archives of Pediatrics and Adolescent Medicine*, *156*(3), 280-295.

Delgado, S. A., Alsabahi, L., Wolff, K,, Alexander, N., Cobar, P., & Butts, J. A. (2017). Demoralizing violence: The effects of Cure Violence in the South Bronx and East New York, Brooklyn. John Jay College of Criminal Justice Research and Evaluation Center.

Diez-Roux, A. V., & Mair, C. (2010). Neighborhoods and health. *Annals of the New York Academy of Sciences, 1186,* 125–145.

Dubow, E. F., Huesmann, L. R., & Boxer, P. (2009). A social-cognitive-ecological framework for understanding the impact of exposure to persistent ethnic-political violence on children's psychosocial adjustment. *Clinical Child and Family Psychology Review*, *12*(2), 113-126.

Dupéré, V., & Perkins, D. D. (2007). Community types and mental health: A multilevel study of local environmental stress and coping. *American Journal of Community Psychology, 39,* 107–119.

Dustmann, C., & Fasani, F. (2016). The effect of local area crime on mental health. The Economic Journal, 126, 978–1017.

Dymnicki, A. B., Henry, D., Quintana, E., Wisnieski, E., & Kane, C. (2013). Outreach workers' perceptions of positive and negative critical incidents: Characteristics associated with successful and unsuccessful violence interruption. *Journal of Community Psychology, 41*(2), 200-217.

Ehrensaft, M. K., Cohen, P., Brown, J., Smailes, E., Chen, H., & Johnson, J. G. (2003). Intergenerational transmission of partner violence: A 20-year prospective study. *Journal of Consulting and Clinical Psychology*, *71*(4), 741-753.

Faul, M., Xu, L., & Wald, M. M, & Coronado, V. G. (2010). Traumatic brain injury in the United States: Emergency department visits, hospitalizations, and deaths 2002-2006. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Federal Bureau of Investigation. (2019). Uniform Crime Report: Texas, table 8. Retrieved from https://ucr.fbi.gov/crime-in-the-u.s/2019/crime-in-the-u.s.-2019/tables/table-8/table-8-state-cuts/texas.xls.

Feldmeyer, B. (2009). Immigration and violence: The offsetting effects of immigrant concentration on Latino violence. *Social Science Research, 38*(3), 717–731.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction

to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine, 14*(4), 245-258.

Feucht, T., & Holt, T. (2016). Does cognitive behavioral therapy work in criminal justice? A new analysis from Crimesolutions.gov. *National Institute of Justice Journal, 277,* 1-8.

Fitzpatrick, K. M., Piko, B. F., Wright, D. R., & LaGory, M. (2005). Depressive symptomatology, exposure to violence, and the role of social capital among African American adolescents. *American Journal of Orthopsychiatry, 75*, 262–274.

Fox, A. M., & Novak, K. J. (2018). Collaborating to reduce violence: The impact of focused deterrence in Kansas City. *Police Quarterly, 28*(3), 283-308.

Franco, M., Diez-Roux, A. V., Glass, T. A., Caballero, B., & Brancati, F. L. (2008). Neighborhood characteristics and availability of healthy foods in Baltimore. *American Journal of Preventive Medicine, 35*, 561–567.

Galea, S., Ahern, J., Nandi, A., Tracy, M., Beard, J., & Vlahov, D. (2007). Urban neighborhood poverty and the incidence of depression in a population-based cohort study. *Annals of Epidemiology, 17*, 171–179.

Gaw, C. E., & Zonfrillo, M. R. (2016). Emergency department visits for head trauma in the United States. *BMC Emergency Medicine, 16,* 5.

Gaylord-Harden, N., Bai G., & Simic, D. (2017). Examining a dual-process model of desensitization and hypersensitization to community violence in African American male adolescents. *Journal of Trauma and Stress,* 30, 463-471.

Gilbert, J., & Elley, B. (2015). Reducing recidivism: An evaluation of the pathway total reintegration programme. *New Zealand Sociology, 30*(4), 15–37.

Goldmann, E., Aiello, A., Uddin, M., Delva, J., Koenen, K., Gant, L. M., & Galea, S. (2011). Pervasive exposure to violence and posttraumatic stress disorder in a predominantly African American urban community: The Detroit neighborhood health study. *Journal of Traumatic Stress, 24*(6), 747–751.

Gorman-Smith, D., & Cosey-Gay, F. (2014). Residents and clients' perceptions of safety and CeaseFire impact on neighborhood crime and violence. University of Chicago School of Social Service Administration.

Gun Violence Archive. (2020). Gun violence deaths in 2019. Retrieved from https://www.gunviolencearchive.org/.

Harris, C. T., & Feldmeyer, B. (2013). Latino immigration and White, Black, and Latino violent crime: A comparison of traditional and non-traditional immigrant destinations. *Social Science Research, 42*(1), 202-216.

Henry, D. B., Knoblauch, S., & Sigurvinsdottir, R. (2014). The effect of intensive CeaseFire intervention on crime in four Chicago police beats: Quantitative assessment. University of Illinois at Chicago (UIC) Institute for Health Research and Policy. Retrieved from https://cvg.org/wp-content/uploads/2019/09/McCormick_CreaseFire_Quantitative_Report_091114.pdf.

Hickner, J. (2018). We need to treat gun violence like an epidemic. *The Journal of Family Practice*, 67(4), 198.

Hinton, E. (2016). *From the war on poverty to the war on crime: The making of mass incarceration in America*. Harvard University Press.

Houston Department of Health. (2020). All health data indicators. Houston State of Health. Retrieved from http://www.houstonstateofhealth.com/indicators/index/dashboard?alias=alldata.

Huesmann, L. R., Moise-Titus, J., Podolski, C. L., & Eron, L. D. (2003). Longitudinal relations between children's exposure to TV violence and their aggressive and violent behavior in young adulthood: 1977-1992. *Developmental Psychology, 39*(2), 201-221.

Irvin-Erickson, Y, Bing, B., Gurvis, A., & Mohr, E. (2016). The effect of gun violence on local economies: gun violence, business, and employment trends in Minneapolis, Oakland, and Washington, DC. Urban Institute. Retrieved from https://www.urban.org/research/publication/effect-gun-violence-local-economies.

Jewkes, R. K., Dunkle, K., Nduna, M., & Shai, N. (2010). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study. *Lancet, 376*(9734), 41-48.

Kalaitzaki, A. E. (2019) The pathway from family violence to dating violence in college students' relationships: A multivariate model. *Journal of Aggression, Maltreatment & Trauma, 28*(3), 313-333,

Kaufman, J., & Zigler, E. (1987). Do abused children become abusive parents? *American Journal of Orthopsychiatry, 57*(2), 186-192.

Kilpatrick, D. G., & Acierno, R. (2003). Mental health needs of crime victims: Epidemiology and outcomes. *Journal of Traumatic Stress, 16*(2), 119.

Kleiman, M. A. R., Caulkins, J. P., & Gehred, P. (2014). Measuring the costs of crime. U.S. Department of Justice. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/grants/246405.pdf.

Landenberger, N. A., & Lipsey, M. (2005). The positive effects of cognitive-behavioral programs for offenders: A Meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology, 1*, 451-476.

LaVeist, T. A., & Wallace, J. M. Jr (2000). Health risk and inequitable distribution of liquor stores in African American neighborhood. *Social Science and Medicine, 51*, 613–617.

Leach, M., & Bean, F. (2008). The structure and dynamics of Mexican migration to new destinations in the United States. In D. Massey (Ed.), *New faces in new places: The changing geography of American immigration* (pp. 99-123). New York, NY: Russell Sage Foundation.

Lee, J. (2012). Wounded: Life after the shooting. *The ANNALS of the American Academy of Political and Social Science, 642*(1), 244–257.

Lee, M., Martinez, R., & Rosenfeld, R. (2001). Does immigration increase homicide? Negative evidence from three border cities. *The Sociological Quarterly, 42*(4), 559-580.

Lemaire, J. (2005). The cost of firearm deaths in the United States: Reduced life expectancies and increased insurance costs. *Journal of Risk and Insurance, 72*, 359-374.

Lessing, B. (2018). *Making peace in drug wars: Crackdowns and cartels in Latin America*. Cambridge: Cambridge University Press

Light, I., & Gold, S. J. (2000). *Ethnic economies*. San Diego, CA: Academic Press.

Lipsey, M. W. (2009). The primary factors that characterize effective interventions with juvenile offenders: A meta-analytic overview. *Victims and Offenders, 4*, 124-147.

Lopez-Humphreys, M., & Teater, B. (2018). Peer mentoring justice-involved youth: A training model to promote secondary desistance and restorative justice among mentors. *Int. Jl. Of Restorative Justice*, 1(*2*), 187-209.

Lopez-Humphreys, M., & Teater, B. (2019a). "It's what's on the inside that counts:" A pilot study of the subjective changes among returned citizens participating in a peer-mentor support initiative. *Jl. Soc. Service Research.*

Lopez-Humphreys, M., & Teater, B. (2019b). Transformations of the self: Learning from the experience of returned citizens participating in a peer mentor support training. *Social Work*, 3 (Supp. S2), 1-25.

Lugo, K., & Przybylski, R. (2019). Estimating the financial costs of crime victimization, final report. U.S. Department of Justice. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/grants/254010.pdf.

Mair, C., Diez-Roux, A. V., & Galea, S. (2008). Are neighborhood characteristics associated with depressive symptoms? A review of evidence. *Journal of Epidemiology and Community Health*, *62*, 940–946.

Mair, C., Diez-Roux, A. V., & Morenoff, J. (2010). Neighborhood stressors and social support as predictors of depressive symptoms in the Chicago Community Adult Health Study. *Health and Place, 16*, 811–819.

Margolin, G., Vickerman, K. A., Oliver, P. H., & Gordis, E. B. (2010). Violence exposure in multiple interpersonal domains: Cumulative and differential effects. *Journal of Adolescent Health,* 47(2), 198-205.

Martinez, R. Jr. (2002). *Latino homicide: Immigration, violence, and community*. New York: Routledge Press.

Martinez, R., Stowell, J. I., & Lee, M. T. (2010). Immigration and crime in an era of transformation: A longitudinal analysis of homicides in San Diego neighborhoods, 1980–2000. *Criminology*, *48*, 797-829.

McCollister, K. E., French, M. T., & Fang, H. (2010). The cost of crime to society: new crime-specific estimates for policy and program evaluation. *Drug and Alcohol Dependence, 108*(1-2), 98–109.

McGarrell, E. F. (2020). Focused deterrence violence prevention at community and individual levels. *Marquette Law Review,* 103(3), 963-981.

Meyer, O. L., Castro-Schilo, L., & Aguilar-Gaxiola, S. (2014). Determinants of mental health and self-rated health: A model of socioeconomic status, neighborhood safety, and physical activity. *American Journal of Public Health,* 104(9), 1734-1741.

Murphy, S. L., Kochanek, K. D., Xu, J., & Heron, M. (2015). Deaths: Final data for 2012. *National Vital Statistics Reports, 63*(9), National Center for Health Statistics.

Murphy, A. K., & Wallace, D. (2010). Opportunities for making ends meet and upward mobility: Differences in organizational deprivation across urban and suburban poor neighborhoods. *Social Science Quarterly, 91*(5), 1164–1186.

National Gang Center. (n.d.). *Cure Violence*. https://www.nationalgangcenter.gov/spt/programs/139

National Research Council. (2008). Parole, desistance from crime, and community integration. Washington, DC*: National Academies Press.*

NYC Office to Prevent Gun Violence. (2020). Interventions. Retrieved from https://www1.nyc.gov/site/peacenyc/interventions/crisis-management.page.

O'Campo, P., Wheaton, B., Nisenbaum, R., Glazier, R. H., Dunn, J. R., & Chambers, C. (2015). The Neighbourhood Effects on Health and Well-Being (NEHW) study. *Health & Place 31*, 65–74.

Ousey, G., & Kubrin, C. (2009). Exploring the connection between immigration and violent crime rates in U.S. cities, 1980–2000. *Social Problems, 56*(3), 447-473.

Papachristos, A. V, Wildeman, C., & Roberto, E. (2015). Tragic, but not random: The social contagion of nonfatal gunshot injuries. *Social Science Medicine*, *125*, 139-150.

Pearson, A. L., Breetzke, G., & Ivory, V. (2015). The effect of neighborhood recorded crime on fear: Does neighborhood social context matter? *American Journal of Community Psychology, 56*, 170–179.

Picard-Fritsche, S., & Cerniglia, L. (2010). *Testing a public health approach to gun violence: An evaluation of Crown Heights Save Our Streets, a replication of the Cure Violence model.* Center for Court Innovation. http://www.courtinnovation.org/sites/default/files/documents/SOS_Evaluation.pdf

Picard-Fritsche, S., & Cerniglia, L. (2013). Testing a public approach to gun violence: an evaluation of Crown Heights Save Our Streets, a replication of the Cure Violence Model. Center for Court Innovation; https://www.courtinnovation.org/sites/default/files/documents/SOS_Evaluation.pdf.

Portes, A., & Rumbaut, R. (2006). *Immigrant America: A portrait, Third edition. Revised, expanded, and updated*. University of California Press.

Prothrow-Stith, D., & Spivak, H. (2003). *Murder is no accident: Understanding and preventing youth violence in America*. San Francisco: Jossey-Bass.

Ransford, C., & Slutkin, G. (2017). Seeing and treating violence as a health issue. In F. Brookman, E. R. Maguire, & M. Maguire (Eds.), *The handbook of homicide* (pp. 601-625). Chichester, West Sussex, England: Wiley-Blackwell.

Rice-Kinder Institute for Urban Research. (2019, March 13). The fight against food insecurity requires teamwork, not competition, new report says. Retrieved from https://kinder.rice.edu/urbanedge/2019/03/08/fight-against-food-insecurity-requires-teamwork-not-competition-new-report-says.

Roman, C. G., Klein, H. J., & Wolff, K. T. (2017). Quasi-experimental designs for community-level public health violence reduction interventions: A case study in the challenges of selecting the counterfactual. *Journal of Experimental Criminology*, Pre-print version.

Ronzio, C. Y., Mitchell, S. J., & Wang, J. (2011). The structure of witnessed community violence amongst urban African American mothers: Latent class analysis of a community sample. *Urban Studies Research, 2011*, 9.

Ross, C. E., & Mirowsky, J. (2001). Neighbourhood disadvantage, disorder, and health. *Journal of Health and Social Behavior, 42*, 258–276.

Rudd, R. A., Seth, P., David, F., & Scholl, L. (2016). Increases in drug and opioid-involved overdose deaths - United States, 2010-2015. *Morbidity and Mortality Weekly Report, 65*(50-51), 1445-1452.

Sampson, R. J., & Bean, L. (2006). Cultural mechanisms and killing fields: A revised theory of community-level racial inequality. In R. D. Peterson, L. Krivo, & J. Hagan (Eds.), *The many colors of crime: Inequalities of race, ethnicity, and crime in America*. New York: New York University Press.

Sampson, R. J., & Jeglum-Bartusch, D. (1998). Legal cynicism and (subcultural?) Tolerance of deviance: The neighborhood context of racial differences. *Law and Society Review, 32*, 777-804.

Shihadeh, E. S., & Barranco, R. E. (2010a). Latino immigration, economic deprivation, and violence: Regional differences in the effect of linguistic isolation. *Homicide Studies, 14*(3), 336–355.

Shihadeh, E. S., & Barranco, R. E. (2010b). Latino employment and black violence: The unintended consequence of U.S. immigration policy. *Social Forces, 88*(3), 1393–1420,

Skogan, W. G., Hartnett, S., Bump, N., & Dubois, J. (2009). Evaluation of CeaseFire-Chicago. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice

Skogan, Hartnett, Bump, & Dubois, 2008; Skogan WG, Hartnett SM, Bump N, et al. Evaluation of CeaseFire-Chicago. Evanston, IL: Northwestern University Institute for Policy Research; 2008. Available at: https://www.ncjrs.gov/pdffiles1/nij/grants/227181.pdf.

Slutkin, G. (2013). Violence is a contagious disease. Contagion of Violence Workshop. Forum on Global Violence Prevention; Board on Global Health; Institute of Medicine; National Research Council. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK207245/.

Slutkin, G., Okware, S., Naamara, W., Sutherland, D., Flanagan, D., Carael, M., Blas, E., Delay, P., & Tarantola, D. (2006). How Uganda reversed its HIV epidemic, *AIDS and Behavior, 4*(10), 351–360.

Slutkin, G., Ransford, C., & Decker, R. B. (2015). Cure Violence: Treating violence as a contagious disease. In M. D. Maltz & S. K. Rice (Eds). *Envisioning criminology: Researchers on research as a process of discovery* (pp. 43-56). Cham, Switzerland: Springer International.

Slukin, G., Ransford, C., & Zvetina, D. (2018). How the health sector can reduce violence by treating it as a contagion. *AMA Journal of Ethics, 20*(1), 47-55.

Spano, R., Rivera, C., & Bolland, J. M. (2010). Are chronic exposure to violence and chronic violent behavior closely related developmental processes during adolescence? *Criminal Justice and Behavior*, 37(10), 1160-1179.

Stockdale, S. E., Wells, K. B., Tang, L., Belin, T. R., Zhang, L., & Sherbourne, C. D. (2007). The importance of social context: Neighborhoods stressors, stress-buffering mechanisms, and alcohol, drug, and mental health disorders. *Social Science and Medicine, 65*, 1867–1881.

Stowell, J. I. (2007). *Immigration and crime: Considering the direct and indirect effects of immigration on violent criminal behavior*. New York: LFB Scholarly Press.

Tcherni, M. (2011). Structural determinants of homicide: The big three. *Journal of Quantitative Criminology, 27*, 475-496.

Texas Department of Public Safety. (2020). Crime in Texas in 2019. Retrieved from https://www.dps.texas.gov/crimereports/19/cit2019.pdf.

Tisak, M. S., Tisak, J., Baker, E. R., & Graupensperger, S. A. (2019). Relations among victimization, witnessing, and perpetration of aggression: Impact of gender among youth offenders. *Journal of Interpersonal Violence, 34*(10), 2158–2180.

Towers, S., Gomez-Lievano, A., Khan, M., Mubayi, A., & Castillo-Chavez, C. (2015). Contagion in mass killings and school shootings. *PLoS One, 10*(7), 117-259.

United States Census Bureau. (2019). Quick facts: Houston, Texas. Retrieved from https://www.census.gov/quickfacts/fact/table/houstoncitytexas,TX/PST045219.

United States Census Bureau. (2019). Quick facts: Houston, Texas. Retrieved from https://www.census.gov/quickfacts/fact/table/houstoncitytexas,TX/PST045219.

U.S. Census Bureau. (2020). QuickFacts: Harris County, Texas. Retrieved from https://www.census.gov/quickfacts/fact/table/harriscountytexas/RHI125219#RHI125219.

United States Department of Justice (DOJ). (2015). Office of Justice Programs. Bureau of Justice Statistics. National Inmate Survey, 2011-2012.

U.S DOJ. (2020a). Violent victimization by race or ethnicity, 2005-2019. Bureau of Justice Statistics. Retrieved from https://www.bjs.gov/content/pub/pdf/vvre0519.pdf.

U.S. DOJ. (2020b). About crime in the U.S. Federal Bureau of Investigation. Retrieved from https://ucr.fbi.gov/crime-in-the-u.s/2019/crime-in-the-u.s.-2019.

Urban Institute. (2018). *Evaluation of Arches transformative mentoring program*. https://www.urban.org/research/publication/arches-transformative-mentoring-program

Vélez, M. B. (2009). Contextualizing the immigration and crime effect: An analysis of homicide in Chicago neighborhoods. *Homicide Studies, 13*(3), 325–335.

Verwimp, P. (2004). Death and survival during the 1994 genocide in Rwanda. *Population Studies, 58*(2), 233-245.

Walters, G. D. (2018). Resistance to peer influence and crime desistance in emerging adulthood: A moderated mediation analysis. *Law & Human Behavior* (American Psychological Association), *42*(6), 520–530.

Webster, D. W., Whitehill, J. M., Vernick, J. S., Parker, E. M. (2012). Evaluation of Baltimore's Safe Streets program: Effects on attitudes, participants' experiences, and gun violence. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health. Retrieved from https://baltimorehealth.org/wp-content/uploads/2016/06/2012_01_10_JHSPH_Safe_Streets_evaluation.pdf.

Webster, D. W., Whitehill, J. M., Vernick, J. S., & Curriero, F. C. (2013). Effects of Baltimore's Safe Streets Program on gun violence: A replication of Chicago's CeaseFire Program. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 90*(1), 27–40.

Weisburd, D., Cave, B., Nelson, M., White, C., Haviland, A., Ready, J., Lawton, B., & Sikkema, K. (2018). Mean streets and mental health: Depression and post-traumatic stress disorder at crime hot spots. *American Journal of Community Psychology, 61*(3-4), 285–295.

Whitehill, J. M., Webster, D. W., Frattaroli, S., & Parker, E. M. (2014). Interrupting violence: How the CeaseFire Program prevents imminent gun violence through conflict mediation. Journal of *Urban Health: Bulletin of the New York Academy of Medicine, 91*(1), 84–95.

Wical, W., Richardson, J., & Bullock, C. (Feb. 2020). A credible messenger: The role of the violence intervention specialist in the lives of young black male survivors of violence. *Violence and Gender*, 7(2), 66-69.

World Health Organization. (2010). Violence prevention: The evidence. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/77936/9789241500845_eng.pdf.

THE HEALTH ALLIANCE *for* VIOLENCE INTERVENTION

Harris County Phase 0 Summary

I. Background

The Harris County Justice Administration Department (JAD) at the request of Harris County Commissioner's Court, with support from Harris County Precinct One, is assessing the feasibility, best practices, and resource needs for bringing a Hospital-based Violence Intervention Program (HVIP) and similar programs to Harris County. HVIPs are multidisciplinary programs that work to identify patients at risk of repeat violent injury and link them with hospital and community-based resources aimed to address the underlying risk factors for violence. The JAD has consulted with the Health Alliance for Violence Intervention (HAVI) to assist in identifying partners for HVIP implementation and to assess interest, readiness, and resource needs of local hospitals to launch a HVIP as early as Fall 2021. During this process the HAVI shared resources and tools with Precinct One and the JAD to support in conceptualizing and planning for HVIP implementation. The HAVI also conducted information sessions with stakeholders, and engaged in stakeholder meetings. Lastly, we reviewed local trauma data and assets in the community to offer Harris County partners recommendations regarding HVIP implementation.

HVIPs combine the efforts of medical staff and trusted community-based partners to provide safety planning, services, and trauma-informed care to violently injured people, many of whom are boys and men of color. HVIPs engage patients in the hospital and continue delivering care after discharge to address both mental and physical health needs, and to prevent reinjury or retaliatory behaviors. Services are provided by culturally competent Violence Intervention Specialists who often also serve in a mentorship capacity. HVIPs require effective partnerships with nonprofit organizations in the community to provide primary program services including intensive, long-term, community-based case management services. This partnership enhances each other's capacity to address crucial healthcare needs. HVIPs are rooted in evidence. Research has shown the HVIP model to be effective at reducing repeat injuries and reducing mortality.

II. List of previously shared tools/resources during Phase 0

The HAVI shared relevant resources with Harris County colleagues throughout Phase 0. A list of key items shared is offered below.

- Data One Pager
- Harris County Workplan
- Sample HVIP Roles and Job Descriptions
- Harris County HVIP Project Scope
- HVIP - Recommended Staffing Roles and Responsibilities
- Harris County HVIP Institute Cohort Program
- Key Components of HVIP
- Fact Sheet_ WHAT IS A HOSPITAL-BASED VIOLENCE INTERVENTION PROGRA…
- HAVI_HVIP Overview.pdf
- HVIP Overview_Phase 0_Ben Taub
- Critical Care: The Important Role of Hospital-Based Violence Intervention Programs
- Sample HVIP budget
- Sample Budget Narrative 2020

III. Engagements with stakeholders

The HAVI conducted information sessions with stakeholders, and engaged in stakeholder meetings, organized by Precinct One and the JAD. Each engagement was aimed at gaining an understanding of interest within the county for implementing and managing a HVIP. Memorial Hermann - Texas Medical Center and Ben Taub Hospital, both Trauma level 1 hospitals located within Harris County, were approached to explore interest, capacity, and feasibility of launching a HVIP. Harris County Public Health, which is committed to providing comprehensive health services and programs to the community, was engaged regarding providing oversight and continued infrastructure for HVIP and other community-based strategies to address community/gun violence. A local community advocate and community stakeholder was also engaged for guidance regarding the need for HVIP work in the county and to identify other

community stakeholders to engage in the effort. Discussions revealed the information provided below.

Memorial Herman, Texas Medical Center (MH TMC) is the largest non-profit hospital in Texas. They are a trauma level 1 hospital and are charged with coordinating injury prevention efforts throughout the community as part of their status. They are the only trauma hospital in Harris County that serves both the adult and pediatric population. MH TMC is also connected to University of Texas Health Science Center at Houston (UTHealth). In an initial meeting with leadership from their injury department and from a subsequent information session with additional hospital leadership,[1] we learned that MH TMC is accustomed to facilitating innovative programs. Their Trauma Medical Director, Dr. Michelle McNutt, is interested in the work because of the volume of violence-related injuries that they see at MH TMC. However, there was concern expressed regarding the County's capacity to adequately fund/support the program.

MH TMC leaders recognize the hospital as a natural point of intervention for victims of violence and consider a HVIP as potentially life changing for participants. However, they reflected on how labor intensive launching a HVIP would be. They indicated a need for information around funding. They requested more details from the County on the expectations for building out the program and number of patients served. Messages of building the program based on capacity, and using hospitalization data to drive target population selection, and consideration to the levels of service that can be provided to patients were shared. A request was made to learn from established HVIPs about their experiences. In response, the HAVI shared contact information for the long-standing, evidence-based Healing Hurt People program in Philadelphia.

Ben Taub Hospital[2] (BTH) is part of Harris Health System. It is a community-focused

[1] Jessica Yell (Clinical Education) jessica.yell@memorialhermann.org, and Sara Beth Abbot (Injury Prevention Outreach and Education)sarah.abbott@memorialhermann.org (main points of contact during phase 0)

[2] strategic-plan.pdf (harrishealth.org)

healthcare system dedicated to improving the health of those most in need in Harris County through quality care delivery, coordination of care, and education. It is a level I trauma center, focused on serving an adult population. BTH provides a wide range of specialty care outpatient services, and it is staffed by physician faculty and residents from Baylor College of Medicine. BTH serves as a teaching facility to the next generation of healthcare providers and is the safety net hospital in the area. The population serviced by BTH is largely underserved, uninsured, low resource residents. In an initial meeting with leadership from their injury department, and a subsequent info session with additional hospital leadership,[3] we learned that BTH has long considered programming to serve the violently injured. However, they were unsuccessful at obtaining the appropriate funding. Their most recent efforts for program funding were put on pause due to the pandemic. Participants of the info session shared that BTH is perceived positively by the community; BTH is situated within the community impacted by violence and is visible and present to meet the needs of the community; and that they have enthusiastic staff to enact this work. They expressed that they would be able to successfully operate a HVIP program if provided with funding and a framework to follow.

Staff in the session spoke of hospital assets that would be instrumental to this work, including their ties to Baylor College of Medicine and Texas Children's Hospital. These institutions provide opportunities for research and replication that would enhance the program impact in Harris County. They spoke of a colleague at Texas Children's Hospital who was awarded a recent grant for a large data collection project that will characterize firearm violence in the county.[4]

Harris County Public Health (HCPH) has recently onboarded a new Executive Director, Barbie Robinson. Director Robinson is eager to support the strategies Harris County is considering implementing, and have HCPH a lead agency in providing infrastructure and resources to the work. HCPH is looking to create efficiencies between community

[3] Includes Kati Barre, Trauma Service and Injury Prevention Coordinator, Katherine.Bare@harrishealth.org (main point of contact); Stephen Mora, Director of Trauma, Dr Chad Wilson, Surgeon.
[4] With new CDC grant, Houston trauma surgeon to study gun violence like it's a disease (houstonchronicle.com)

violence strategies (hospital-based violence intervention and street outreach/violence interruption).

Director Robinson expressed a readiness to operationalize the different pieces to the work but also wanting to allow the time needed to stand up efficient, quality programming. Director Robinson has requested the County build a budget that factors in components of need for services across the social determinants of health. Her request is for program operations and administrative support for implementation. Director Robinson expressed that the success of the program will be based on the ecological perspective, emphasizing the need for programming to address both individual and social environmental factors that contribute to violence. This perspective highlights a need for interventions that are directed at changing interpersonal, organizational, community, and public policy level factors that create disparities in health outcomes.

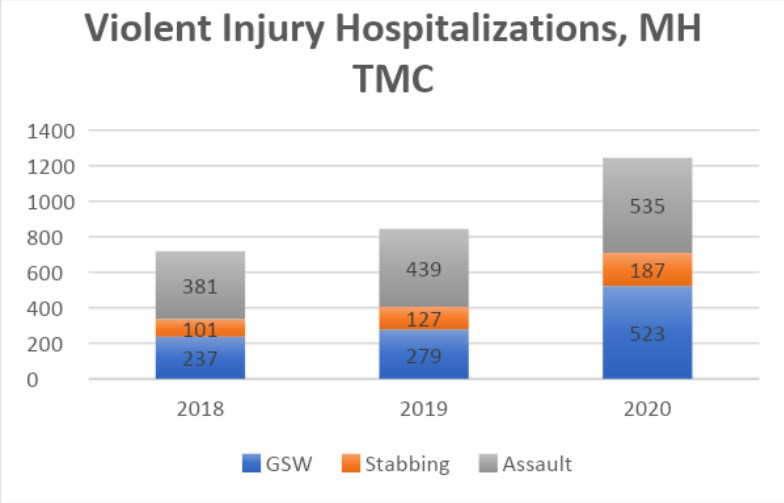
Director Robinson shared interest in safety net programming (a model for working with homeless people and people with medical conditions). She wants to establish a multidisciplinary approach and ensure wrap-around care/services. There is also an interest to build capacity for community health workers. Director Robinson noted that she has a relationship with Dr Porsa, CEO of Ben Taub Hospital, and has spoken to him about partnership. Director Robinson has a strong preference to begin HVIP planning with BTH (possibly expand later), because BTH is part of the safety net system. They are responsible for the broader healthcare of the population of interest. She feels that her division will be able to create an impact with BTH more effectively.

Reginald Gordon is a community stakeholder and local advocate connected to United in Peace Houston. This grassroots organization works to empower youth to prevent and reduce violence through outreach services, serving youth that are presently incarcerated or recently released. They provide outreach services, peer groups, family/school/community-based programs and services that address trauma among youth aged 17-25. Reginald expressed that BTH is connected to the community and would be a good partner to establish a HVIP. He also expressed that Harris County lacks

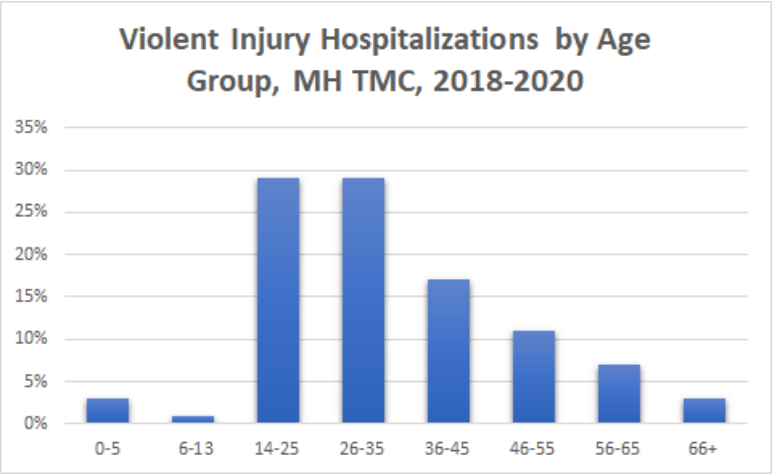
the presence of CBOs dedicated to community violence intervention and has an under-investment in the nonprofit sector. Reginald explained that violence should be addressed in the same ways as the opioid crisis; with a similar approach (e.g., staffing, and coaching). He referenced HEROES - Heroes - The University of Texas Health Science Center at Houston (UTHealth) School of Biomedical Informatics as an example. He proposed that a HVIP can operate in the same way as drug recovery program in the hospital trauma departments.

IV. Trauma data review

A review of MH TMC hospitalization data (source: trauma registry)

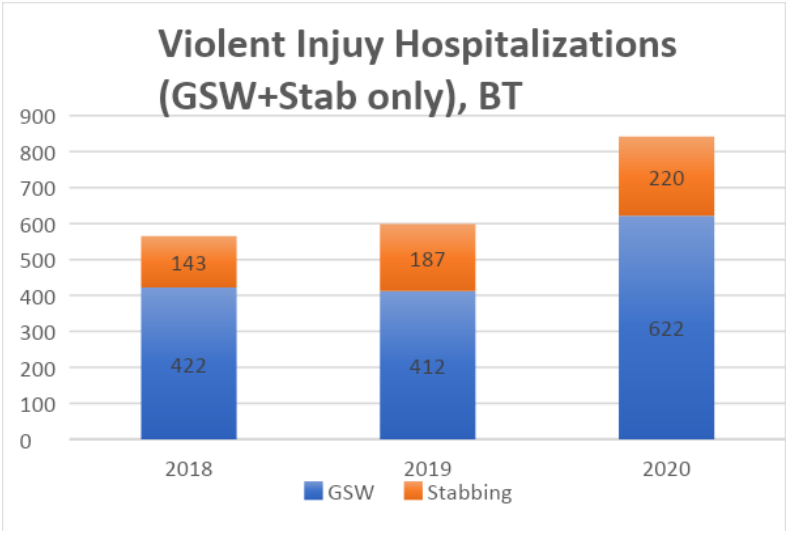


Violent injury hospitalizations for years 2018, 2019, and 2020 were 719, 849, and 1245, respectively. That is a 42% increase in violent injury hospitalizations from 2018 to 2020. This increase was largely due to a spike in gun violence (gunshot wounds (GSW)) in 2020.



Over the 3-year time period, an average of 58% of violent injuries occurred between ages 14-35, 75% of injuries occurred between ages 14-45.

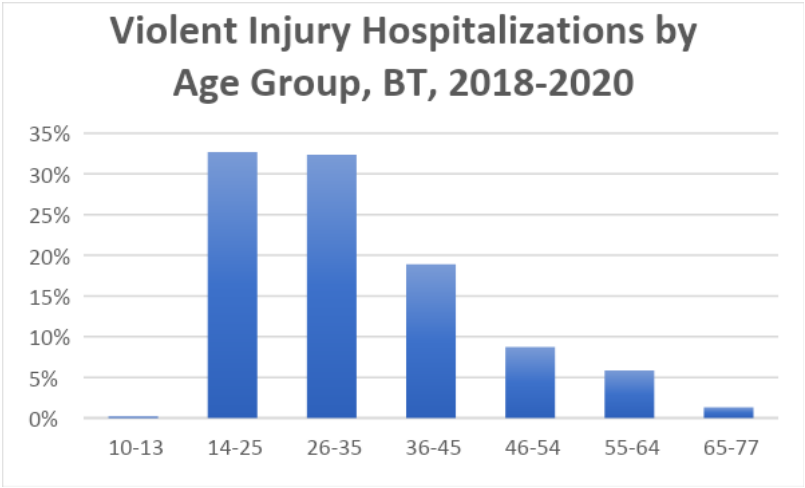
Additionally, greater than 40% of hospitalizations were among Blacks, and the overwhelming majority (approximately 80%) of injuries occurred among men. As it pertains to gun-related injuries, 63% of **all** gun-related injuries seen at the MH TMC during the 3-year period were the result of violence, followed by accidental shootings (20%), and acts of self-harm (9%).



A review of Ben Taub hospitalization data (source: trauma registry)[5]

Violent injury hospitalizations due to GSW and stabbings for years 2018, 2019, and 2020 were 565, 599, 842, respectively. There was a 33% increase in GSW and a 35% increase in stabbing hospitalizations from 2018 to 2020. Assault-related data not obtained for BTH.

Over the 3-year period, there were 550 more GSW and stab injury hospitalizations seen at BTH than at MH.



Over the 3 year-time period, an average of 65% of injuries occurred between ages 14-35; 84% of injuries occurred between ages 14-45.

The overwhelming majority (approximately 88%) of injuries occurred among men. No race/ethnicity data was provided.

Table 1 shows the leading zip code of residence for patients that were hospitalized with violent injuries from a gunshot wound or stabbing for years 2018-2020. The most common (frequently occuring) zip codes during the 3-year time period were, 77021, 77033, 77004, 77087, 77030, 77026, 77036, 77051.

Table 1.Top 5 Zip Codes of Residence for Violently Injured Patients

	2018	2019	2020
1	77021	77021	77021
2	77033	77033	77033
3	77004	77026	77004
4	77087	77004	77036
5	77030	77087	77051

Table 2 shows the leading zip codes for the location where the gunshot or stabbing injury took place. The most common (frequently occuring) zip codes during the 3-year time period were, 77021, 77033, 77004, 77051, 77002, 77026, 77021, 77036.

Table 2. Zip Codes for Location of Violent Injury

	2018	2019	2020
1	77021	77033	77021
2	77033	77021	77036
3	77004	77026	77004
4	77051	77004	77051
5	77002	77002	77033

These data show a direct overlap in the leading home zip code in table 1, and the zip codes for location of violent injury.

V. Community assets

Through a bedside intervention, HVIPs provide a hospital-based response and build trusting relationships with violently-injured people. HVIPs interrupt the cycle of violence and provide intensive case management and follow-up services that address the social determinants of health of those impacted by violence.

Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Addressing inequities in the social determinants of health of clients involves engaging networks of community services and resources as part of programming and giving voice to patients who have experienced harm.

<u>Most commonly needed services</u>

- General health care assistance
- Victim services compensation
- Anger management classes
- Emergency funds (clothing, utilities, housing)
- Legal advocacy
- Transportation assistance

- Housing assistance
- Educational assistance & advocacy (*e.g., GED prep classes, tutoring, alternative/special ed placement*)
- Job training/placement programs
- Mental health evaluation & counseling
- Substance abuse counseling

Accessibility and quality of services in your network should be considered. Clients ultimately should feel safe and supported in the case management and referral process. A preliminary scan of community assets in Harris County reveals limited investments in community-based social services. Existing resources that can be explored and considered for inclusion in the HVIP service network are listed below. Information needed on available services is offered below in the template Service Directory grid.

Sample of Assets

Community Services Rental Assistance Bereavement	Reentry services Community Re-Entry Network Program
Behavioral Health Services The Harris Center	Food Services Gulf Coast Community Service Association Food Distribution for Houston | Target Hunger

Service Directory Template

Resource Type	Agency	Address	Contact Name	Title	Phone	Email	Service description	Fees	Eligibility	Enrollment process	Referral forms	Other info.

VI. Recommendations:

Hospital partner

- While both MH TMC and BTH recognize the burden of violence in their communities and recognize the hospitals as a point of intervention, BTH emerged as a better starting point for establishing the first HVIP in Harris County, especially given the County's timeline for implementation. With additional resources, consider expansion into MH TMC or Lyndon B. Johnson Hospitals. Conversations with MH TMC can continue with the aim of potential program implementation down the line. They are in need of more information and discussion about the HVIP model and different model types, county funding commitments and other funding opportunities. Continue to engage MH Trauma Medical Director, Dr Michelle McNutt as County plans unfold. Dr McNutt is interested in the work and lifts up the operational concerns that will need to be addressed for any future work to be considered.
- BTH is interested in the work and eager to engage the County further on opportunities that exist for resources and support. Consider trauma services (in collaboration with the emergency dept and social work) for the program home within the hospital.
- Obtain executive level buy-in for establishing a program at BTH. Offer concrete details about the County's intended financial commitment and advocacy for this work.
- As HVIP planning begins implementers of the program should convene would be champions of the work including, the Medical Examiner Office; Dr David Persse, Chief Medical Director for HFD EMS; the Houston Police Dept Anti-gang Task Force; Community Organizations; health clinics they have worked with; and mental health partners/orgs. Champions can inform the work and can collaborate around resources.
- Explore BTH connections to community-based services, like mental health resources, to build a service network for referral.
- Identify partners to implement the violence prevention services (e.g. case management.

- Contract with the HAVI for training and technical assistance services that will be instrumental to HVIP planning, launch and sustainability.

Harris County Public Health (implementing partner)

- There is a level of complexity in standing up community violence prevention strategies. However HCPH, through Director Robinson and other leadership like Deputy Director Gwenn Sims, seems to be keenly aware of this and understands the need for these intervention strategies.
- Harris County is proposing the creation of a Division of Community Health and Violence Prevention Services within Harris County Public Health. Harris County should ensure multi-year funding and resources to allow HCPH to administer interdisciplinary initiatives including a HVIP.
- As part of this effort, HCPH should factor in components of need for services across the social determinants of health to add a multidisciplinary approach to the work.
- As the hospital-based work is being discussed for implementation, it is important to maintain the integrity of the model and to the role of the violence interventionist. The HVIP model can work alongside other models of intervention and care, however evidence indicates the need for community involvement and for workers that have lived experience and strong community connections.

  Violence Interventionists (VIs) - Serve as an advocate and resource navigator for program participants. They build trust and rapport through engagement and support. Ideally, someone with lived experience similar to the patient population and/or demonstrated ability to deeply understand the needs and dynamics of individuals impacted by community violence. VIs provide immediate and long-term case management and emotional support and work with participants in the hospital and post-discharge.
- Consider the coordination that will be needed between intervention strategies, like with the HVIP and the proposed Coordinated Care Team. Allow for critical thought and planning on when hand offs between the violence interventionist

and the CCT happen and how. Ensure there are an adequate number of Violence interventionists to start the program (2-3).

Community partner

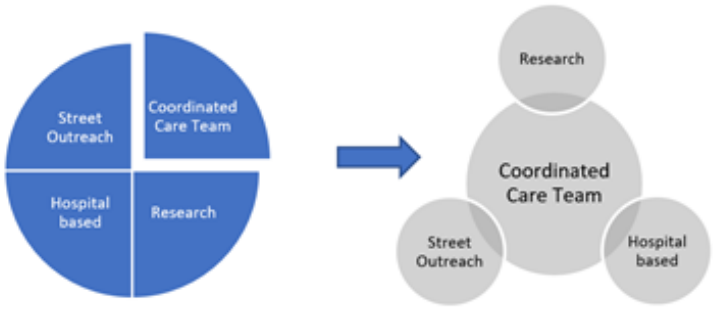
- Community stakeholders for community violence prevention were identified and were part of a community mapping project conducted by Dr. Chico Tillmon, under the direction/collaboration of Precinct One and the JAD. This work should be used to guide community partnership building.
- Consider engaging the following stakeholders to inform and contribute to the work.
    - **Lina Hidalgo**, Harris County Judge – solicit support in advocating for sustained funding.
    - **Barbie Brashear,** Harris County Domestic Violence Council - a collaborative of over 40 different orgs/stakeholders.
    - **Dieter Cantu,** Harris County Youth Collective - a broad based collaborative that advocates for youth involved in the child welfare and juvenile justice system.
    - **Joel Levin,** Harris County Resources for Children and Adults – a network of county-based services and case management.
    - **Advance Peace** interrupts gun violence in American urban neighborhoods by providing transformational opportunities to young men involved in lethal firearm offenses. Advance Peace is a national organization operating within different regions.
    - **Pure Justice** is a champion in restorative justice practices, equity in economic opportunities, and transformation of the criminal justice and economic structures of Harris County.
    - **Deric Muhammad,** Houston-based Activist/Organizer who addresses issues regarding Social Justice, Black Male Youth Development, Police Brutality, Racial Inequality and other issues.

- **Abdul Muhammad**, PhD, Organizer; Founder/CEO, A.C.T.I.O.N. CDC

Program design

- More thought and discussion is needed to continue to determine how the violence interventionists, an integral part of HVIPs, will work in the community and in the hospital context. It is recommended that the violence interventionist maintain the risk assessment and safety management of participants in the hospital and continue the intensive case management overtime. The proposed coordinated care team (CCT) should focus on interfacing with the violence interventionist and with the participant to a lesser extent. The CCT can play a central role in identifying resources and will be a support to the violence interventionist. Consider a structure that models the second image in figure 1 below.

Figure 1.



VII. Opportunities for HVIP Funding

There are several opportunities for funding and advocacy in support of innovative community-based strategies for community violence intervention and prevention. A sample of related opportunities are below:

1. There are federal funding streams that can be taken advantage of now or in the near future to support hospital-based violence intervention programs. Numerous

funding streams can be used for violence intervention efforts including an increased number of grants available through the Victims of Crime Act (VOCA), Edward Byrne Memorial Justice Assistance Grants and Department of Housing and Urban Development grants, for example. State and local agencies can advocate for how these varying funding streams can be spent to support community-based services and violence intervention. While some grant deadlines have passed, reference resources below to learn of opportunities and topic areas of interest for federal funding in support of community violence interventions (CVI) now and in the future.

- White House's fact sheet on Biden's strategy
- FACT SHEET: More Details on the Biden-Harris Administration's Investments in Community Violence Interventions | The White House

2. Advocate to members of Congress to ask for their support for a robust jobs and infrastructure package that includes $5 billion in community-based gun violence prevention programs.
3. Advocate for community project funding ("earmarks") for community violence interventions.
4. Advocate for funding through the American Rescue Plan for community violence interventions in your city, county, and/or state budgets.
5. Some states have created state-based grant programs that provide competitive grants to fund programs with the goal of reducing violence in their local city and adjacent areas. For example,
   - California Violence Intervention and Prevention (CalVIP) grant program
   - The Maryland Violence Intervention and Prevention Program Fund (VIPP)
     - Maryland Violence Intervention and Prevention Advisory Council - Governor's Office of Crime Prevention, Youth, and Victim Services
6. State-based advocacy to enable community violence prevention services to be reimbursable under Medicaid. States like Connecticut and Illinois have recently passed related legislation. Medicaid reimbursement provides a longer-term strategy for funding, and adds diversity in funding.
   a. Connecticut looks to use Medicaid funds to address gun crime (apnews.com)

7. Research funding opportunities with foundations with an interest in gun or community violence prevention, trauma informed and restorative justice practice, disparities impacting the health of boys and young men of color, and systems change, like the Joyce Foundation, Arnold Ventures, Kresge Foundation, Langeloth Foundation.

VIII. Conclusion

Harris County's interest in investing in community-based approaches for violence intervention is commendable. This assessment of buy-in and readiness among County stakeholders reveals interest in the HVIP model and a need to share more information about resources coming from the county to begin and sustain the work. There is also a need to ensure community involvement in the building and staffing of the HVIP. Harris County should firmly describe their role and expectation as conversations with stakeholders and implementers progress and as intervention planning takes shape. There is a need for the County to continue leading the efforts toward acquiring multi-year funding. The County should work in partnership with HCPH, the hospital and community partners to budget for personnel and multidisciplinary resources needed. Lastly, HAVI services should be retained to further support planning and launch of the hospital-based violence intervention. Training and technical assistance specific to partnership building, program implementation, case management and performance monitoring will be valuable to the success of the program.

Programming to Address Violence

August 10, 2021

Agenda

- Background
- Trends in Violent Crime
- The Public Health Approach
- Office of Public Health
- Community Violence Interruption Programs
- Hospital-Based Violence Interruption Programs
- Best Practices
- Conclusion

Background

- Court motion:

I move to approve the Justice Administration Department, Commissioners Court Analyst's Office, and Public Health analyze the feasibility and cost of creating a new county level agency or program to administer violence interruption programs based on proven public health techniques to end cycles of violence in the community. The study should contemplate that this agency or program would operate independent of law enforcement. The initial report on the findings of the study should be provided within 30 days. Once the report is complete, there will be a public hearing.

- Report by Commissioners Court Analyst's Office delivered on July 9.
- Collaboration between JAD, Precinct 1, and consultants since delivery.

Trends in Violent Crime

- Increases in violent crime (especially murders and aggravated assaults) across the country and in Harris County.
- Across US and in Harris County increases are most notable in most disadvantaged communities.
- This points to the need for an approach that addresses the *root causes of violence*.

The Public Health Approach

- Jurisdictions across the country are adopting the public health approach to identify and address the root causes of violence.
- Steps to the public health approach:
  - Define the problem
  - Identify risk and protective factors
  - Develop and test prevention strategies
  - Assure widespread adoption

Offices of Public Health

- Cities across the country have created non-law enforcement offices to diagnose and “treat” violence like the public health crisis it is.
- Those departments address violence through targeted interventions.
- This approach has durably reduced violence in jurisdictions like Richmond, CA, where homicides were reduced by 40%.
- The reports this transmittal accompanies examine two programs that would be implemented under the Division of Community Health and Prevention Services
  - Community-Based Violence Interruption Program (Street Outreach)
  - Hospital-Based Violence Interruption Program

Street Outreach Programs

- Such programs are often derived from CureViolence in Chicago, which reduced violence in disadvantaged neighborhoods on the South and West sides.
  - Effectively adapted in Brooklyn, Baltimore, Phoenix, and elsewhere.
- **Violence Interrupters** with credible lived experience canvass communities and stop violence before it starts.
- **Outreach Workers** connect individuals at greatest risk of perpetrating and experiencing violence with community resources to help them desist.
- Program structure, opportunities for implementation, best practices, implementation areas, and review of related programs described in report submitted by Tillmon Training and Consulting to today's court.

Hospital-Based Violence Interruption Programs

- These programs have been implemented in many emergency departments across the country.
- Individuals hospitalized after violent injury/assault that are at risk of retaliating or being injured again are counselled, connected to community resources, and offered case management.
- Such programs drastically reduced reinjury rates in San Francisco, Oakland, Chicago, Maryland, and other cities.
- A report on implementation elsewhere, a background on best practices, and an overview of implementation opportunities in Harris County Trauma Centers, was compiled by the Hospital Alliance for Violence Intervention, and is attached.

Best Practices

- Insure programs are implemented in areas that have both high need and a high ability to staff and implement a program.
  - Accomplished through asset mapping produced by consultants.
- Produce a sophisticated and compelling evaluation of the program to ensure that progress is measured and reported to community members.
  - Harris County Public Health is continuing to collaborate with consultants to facilitate rigorous evaluation.

Conclusions

- These programs will not completely eliminate violence in Harris County. But they will ease the root causes which drive violence, and enable law enforcement to more effectively protect our neighbors.
- Harris County Public Health will continue to collaborate with consultants identified here, policy analysts from the Commissioners Precincts, the Justice Administration Department, and HCSO to identify and implement pioneering policies that reduce violence with a public health approach.